

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13010

CERTIFICATE OF DEATH

13014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>46 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>31 1/2 E. Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Marshall</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Protection</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berkley Springs, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George William Allen</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-09-5618</u>		17. INFORMANT <u>Mrs. Lena Allen 31 1/2 E. Franklin St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion with</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24 Sept, 1967</u> , to <u>death</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>24 Sept</u> 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>John C. Stauffer, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>				22d. ADDRESS <u>145 S Prospect St. Hagerstown., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10/19/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13011

13015

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg		d. STREET ADDRESS 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lelia Middle Mae Last Bachtell		4. DATE OF DEATH Month Sept. Day 18 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington Co., Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Moser		14. MOTHER'S MAIDEN NAME Susan Nicholas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Mrs. Egerett Needy		Address Smithsburg R.D.3, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inferior Myocardial Artery Thrombosis 4331 DUE TO (b) Arrhythmia DUE TO (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 Days 6 mo. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-30, 1966 , to 9-18, 1967 , that (I) (we) last saw the deceased alive on 9-17, 1967 , and that death occurred at 3:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles G. Hens		22b. DATE SIGNED 9-18-67	
22c. PHYSICIAN'S NAME (Type) Charles G. Hens		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/1967	
23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Lantz Frederick Md.	
24. FUNERAL DIRECTOR Walter G. Lutz		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Lutz		25c. REGISTRAR'S NAME Waynesboro, Penna.	

CERTIFICATE OF DEATH

Washington

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Susan Nicholas

Clarence Foster

Baltimore, Md.

Mrs. Ernest Needy

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Baltimore

Baltimore, Md.

CERTIFICATE OF DEATH

13016

Reg. Dist. No.

13012

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>11 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Friendship Manor Home</u>		d. STREET ADDRESS <u>R.D. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Anne R.</u> Middle <u>Baker</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1881</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Knight</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Burkholder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Kenneth Baker, Cascade, Md. R.D. # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cr Dis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Valvular Dis. of Heart</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-23</u> , 19 <u>66</u> to <u>9-9</u> , 19 <u>67</u> that I last saw the deceased alive on <u>9-8</u> , 19 <u>67</u> , and that death occurred at <u>6:45 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert P. Conrad</u> M.D.		ADDRESS (Street, city or town, state) <u>1374 Washington</u> DATE SIGNED <u>9-9-67</u>	
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 11, 1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairfield Union Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fairfield, Adams Co. Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence E. Wilson</u>		24a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
ADDRESS <u>Emmitsburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13013

13017

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Edgar</u> Last <u>Beckley Sr.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silk Weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank H. Beckley</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda A. Weller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-09-6422</u>		17. INFORMANT <u>Mrs. Myrtle Beckley R # 2 Williamsport, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>9-12</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>9-11</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Hawk</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25. REC'D BY REGISTRAR DATE <u>SEP 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

13017
13018

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VENICE MOTEL				d. STREET ADDRESS 3226 CLIFTMONT AVENUE			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HARRY BENNETT				4. DATE OF DEATH Month Day Year SEPTEMBER 18, 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 24, 1911		9. AGE (In years last birthday) 55 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY STATE ROADS COMM.		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PENNSYLVANIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES M. BENNETT				14. MOTHER'S MAIDEN NAME ISABEL BELLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No yes WW2***				16. SOCIAL SECURITY NO. 215-07-0318		17. INFORMANT MRS. IDA V. BENNETT, BALTIMORE, MARYLAND.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, Jr.				M.D. 9/19/67			
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.				22. DATE SIGNED 9/19/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9/21/67		23c. NAME OF CEMETERY OR CREMATORY PARK WOOD CEMETERY, BALTIMORE, BALTIMORE CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR SEP 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

13015

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Cumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg 753	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Virginia Ave.		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbur Middle S. Last Bolen		4. DATE OF DEATH Month September Day 9 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-95
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general bus.	
11. BIRTHPLACE (State or foreign country) Newburg, Penna.		12. CITIZEN OF WHAT COUNTRY? Penna.	
13. FATHER'S NAME Lee Bolen		14. MOTHER'S MAIDEN NAME Marjorie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW I		16. SOCIAL SECURITY NO. 479012-3877	
17. INFORMANT Mrs. Edna Smith, Newburg, Penna.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary atherosclerosis, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) severe ischemic fibrosis of left ventricle DUE TO (c) cardiac hypertrophy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 217 W. Wash. St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-12-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City or Town) (County) (State) Upper Mifflin, Penna.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CONFIDENTIAL - SECURITY INFORMATION

San Antonio, Texas

San Antonio, Texas

Virginia Ave.

Wilson

White

Isidor

Los Angeles

Los Angeles

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13016

13020

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vertie Odessa Bridendolph		4. DATE OF DEATH Month Day Year Sept. 3, 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1885
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John BURAN		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-14-9709	
17. INFORMANT MRS. PEARL HOUSE-13		Address RD-2 CLEAR SPR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 6 weeks unknown years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Arteriosclerosis, general		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from July 18, 1967 , to Sept. 3, 1967 , that (1) was saw the deceased alive on Sept. 3, 1967 , and that death occurred at 10:25 A.M. from causes and on the date stated above			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Sept. 3, 1967	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL Specify BURIAL	23b. DATE THEREOF SEPT. 6, 67	23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MATERNAL	23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR Donald E. Thompson		25a. REC'D BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME THOMPSON FUNERAL HOME CLEARSPRING	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15

WESTERN NATIONAL LIFE INSURANCE CO.
DEPARTMENT OF VITALS
CHICAGO, ILL.
No. 1000
Name: John Bush
Age: 47 years
Sex: Male
Date of Birth: June 24, 1882
Date of Death: Sept. 3, 1927
Place of Death: Chicago, Ill.
Cause of Death: Heart Disease
Buried: Yes
Burial Place: Holy Sepulchre Cemetery, Chicago, Ill.

WESTERN NATIONAL LIFE INSURANCE CO.
DEPARTMENT OF VITALS
CHICAGO, ILL.
No. 1000
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VR A15 (4)
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>					c. LENGTH OF STAY IN 1b <u>50 YRS.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD. STATE HOSPITAL</u>					d. STREET ADDRESS <u>758 SPRUCE ST.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET</u> <u>EMMA</u> <u>BROOKS</u>					4. DATE OF DEATH Month Day Year <u>9</u> <u>9</u> <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/1899</u>		9. AGE (in years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>BENJAMIN MYERS</u>					14. MOTHER'S MAIDEN NAME <u>REBECCA DALEY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>24-09-3514</u>				
17. INFORMANT <u>MR. WARREN C. BROOKS</u>					Address <u>HAGERSTOWN MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>2001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphosarcoma with metastasis</u> DUE TO (c)									<u>2-3 days</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-6-1967</u> to <u>9-9-1967</u> , that (I) (we) last saw the deceased alive on <u>9-9-1967</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Domingo A. Garcia</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>September 9, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Domingo A. Garcia</u>					22d. ADDRESS <u>WESTERN MARYLAND STATE HOSPITAL</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN, WASH. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.J. Harment, Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>40yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>432 N. Jonathan Street</u>		d. STREET ADDRESS <u>432 N. Jonathan Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>May</u> Last <u>Cook</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26 1890</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George King</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Calman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Dorothy William</u>		Address <u>432 N. Jonathan St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u> <u>not known</u> <u>Not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> , to <u>9/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank R. Diego</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK R. DIEGO</u>		22b. DATE SIGNED <u>9/29/67</u>	
22d. ADDRESS <u>119 E. Antietam St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 2 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Towson Chapel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Md.</u>	
24. FUNERAL DIRECTOR <u>John R. Watson Jr.</u>		ADDRESS <u>Hagerstown Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	

SECRET

CERTIFICATE OF DESIGN

1000



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[illegible text block]

[Large block of illegible text, likely a detailed report or certificate body]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 65 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 147 S. Mulberry St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leah Catherine Cramer			First Middle Last		4. DATE OF DEATH September 3, 1967				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-96		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Greencastle, Pa.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Grumbine					14. MOTHER'S MAIDEN NAME Mary Clopper				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Herman Hull, Baltimore, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None									INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug 28 , 19 67 to 9-3 , 19 67 that (I) (we) last saw the deceased alive on 9-3 , 19 67 , and that death occurred at 11:30 M, from the causes and on the date stated above.									
22a. SIGNATURE M.E. Byrkit			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-5-67		
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit			22d. ADDRESS Williamsport Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 9-7-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR SEP 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

Washington, D.C. 20540
U.S. Department of Justice
Federal Bureau of Investigation

Washington, D.C. 20540
U.S. Department of Justice
Federal Bureau of Investigation

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

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Washington County, Maryland

Washington County, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13020

13024

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Hook, Route #67 & 340</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harpers Ferry</u> d. STREET ADDRESS <u>Route #I</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard Edward Crawford</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/4/08</u> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>1962</u> IF UNDER 24 HRS.: Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer B&O R.R.</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Piedmont West Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Seymour Crawford</u> 14. MOTHER'S MAIDEN NAME <u>Ellen Louise Cooper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>no</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Emma Mae Crawford</u> Address <u>Harpers Ferry, W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull fracture c Brain Stem</u> DUE TO (b) <u>Injury</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Fractured Neck.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of Auto Struck Bredside by another speeding Auto</u>		20c. TIME OF INJURY Month, Day, Year <u>9-11-1967</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>19467 + 340</u> 20f. (City or town) <u>Sandy Hook Wash</u> (County) <u>Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-11-67</u> ACTUAL SIGNATURE <u>Edward W. Ditto III, M.D.</u> EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/15/67</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Duland Cemetery Brunswick, Md.</u> 22d. LOCATION (City, town, or country) <u>New Creek, West Virginia</u> (State)		24. REC'D BY REGISTRAR <u>SEP 14 1967</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



SEP 11 1944
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C.

MARYLAND-STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13025

13021

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cavetown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Stanley Detrow		4. DATE OF DEATH Month Day Year September 11, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1882
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5 17	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Beaver Creek, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob H. Detrow		14. MOTHER'S MAIDEN NAME Barbara Easton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 218-24-2029	
17. INFORMANT Mr. Edgar L. Detrow, Boonsboro Rfd. 2, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/6, 19 67 to 9/11, 19 67 , that (I) (we) last saw the deceased alive on 9/11, 19 67 , and that death occurred at 4:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE A.M. Mandell		22b. DATE SIGNED 9/14/67	
22c. PHYSICIAN'S NAME (Type) A.M. Mandell, M.D.		22d. ADDRESS 34 301 E. Antietam, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-14-67	
23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECOMMENDATIONS

The following recommendations are based on the findings of the
Commission on the Prevention of the Influenza Pandemic,
which was organized by the United States Department of Health
in 1918. The Commission was composed of representatives of
the various branches of the Government, and of leading
experts in the field of public health. Its report, which
was published in 1919, contains a number of valuable
suggestions for the prevention of the influenza pandemic.
The following are some of the most important of these
recommendations:

X

1. The first and most important recommendation is that
the Government should take prompt action to prevent the
spread of the influenza virus. This can be done by
quarantining persons who are infected with the virus,
and by isolating them from the general public. It is
also recommended that the Government should provide
for the care of these persons, and that it should
take steps to prevent the spread of the virus to
other persons.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13022

CERTIFICATE OF DEATH

13026

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rfd. 2			
3. NAME OF DECEASED (Type or print) First Stella Middle Geneva Last Detrow				4. DATE OF DEATH Month September Day 19 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1896	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 6 Days 23 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Beaver Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Scadden				14. MOTHER'S MAIDEN NAME Elizabeth Bowers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Edgar L. Detrow, Boonsboro Rfd. 2, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstructive Emphysema - Rupture of Bleb (c) in left Lung - end Hemorrhage - left						INTERVAL BETWEEN ONSET AND DEATH 9/13/67 7/13/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 67 , to 9/19 , 19 67 , that (I) (we) last saw the deceased alive on 9/14 , 19 67 , and that death occurred at 9:30 AM , from causes and on the date stated above.							
22a. SIGNATURE Sidney Novenstein				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-20-67	
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN				22d. ADDRESS FUNKSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-67		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Beaver Creek, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MAINTAIN A RECORD OF ALL INFORMATION RECEIVED FROM ANY SOURCE

STATEMENT OF FACTS

1. Name of Subject: [illegible]
2. Date of Birth: [illegible]
3. Place of Birth: [illegible]

4. Present Address: [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

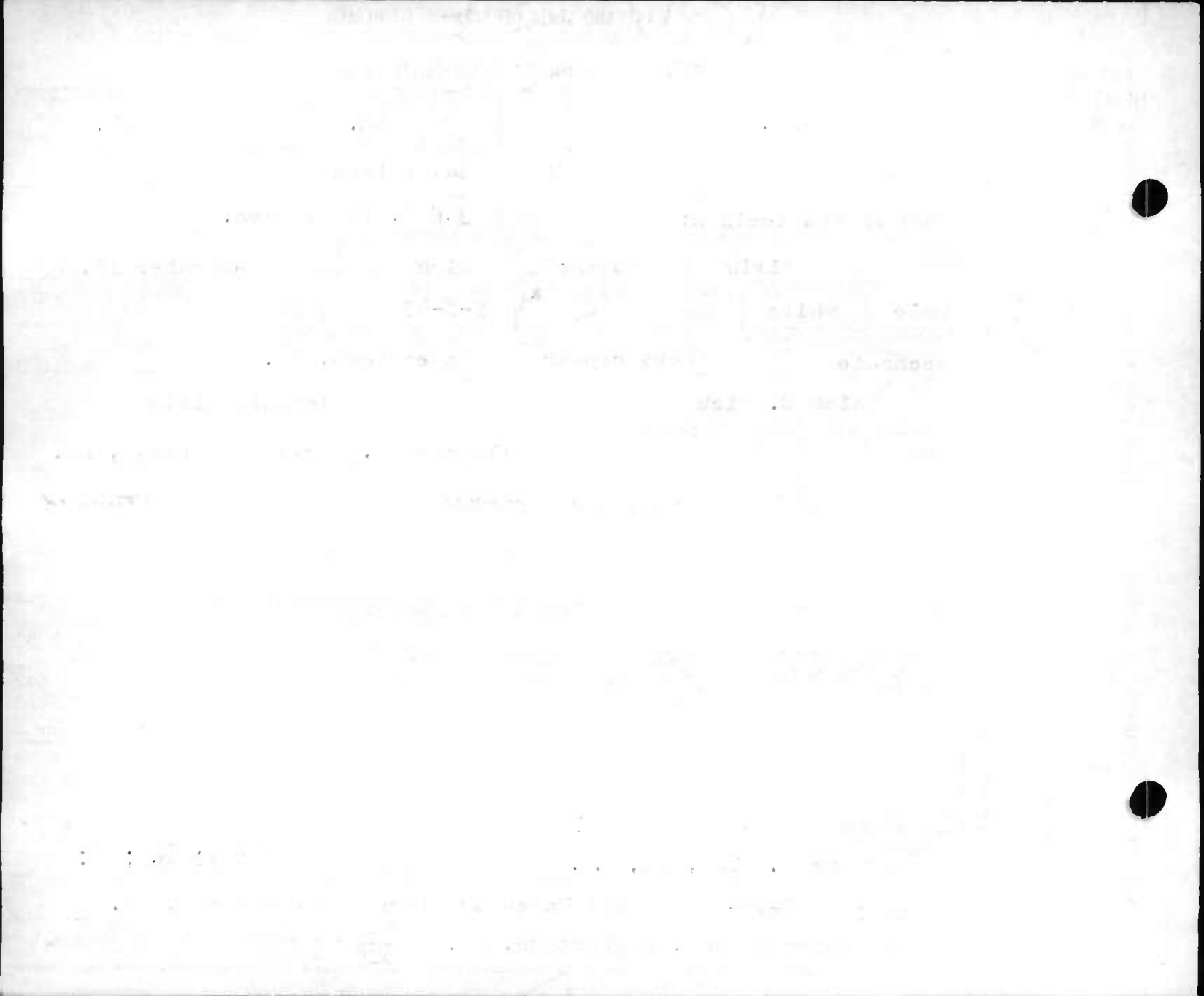
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13023

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 24 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Scene of the accident		e. STREET ADDRESS 368 S. Cannon Ave.	
3. NAME OF DECEASED (Type or print) First Alvin Middle Eugene Last Dick		4. DATE OF DEATH Month September Day 11 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-43
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY auto repair	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ralph C. Dick		14. MOTHER'S MAIDEN NAME Florence Alsip	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Florence J. Dick, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Neck DUE TO (b) 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Turned	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant in Auto Struck by another Auto Intersect		
20c. TIME OF INJURY Month, Day, Year 10 30 p.m. 9-11-1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Hagerstown (County) Wash (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Wash. St.	
		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 9-14-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md. (County) (State)
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 14 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hedgesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Route 1 (North Mountain)	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Raleigh Dirting		4. DATE OF DEATH Month Day Year September 19 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft	
11. BIRTHPLACE (County & State, or foreign country) Berkeley County, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Lemuel Dirting		14. MOTHER'S MAIDEN NAME Ruth Robbins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 234-24-4978	
17. INFORMANT G.L. Dirting-Hedgesville, Rt. 1, W.Va.,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain aneurysm 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Jaundice, anemia, cause undetermined (see report)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 18, 1967 to Sept 19, 1967 , that (I) (we) last saw the deceased alive on Sept 18, 1967 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Edson B. Moody		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody		22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1967	
23c. NAME OF CEMETERY OR CREMATORY Hedgesville Cemetery		23d. LOCATION (City, town or county) (State) Hedgesville, Berkeley, W.Va.	
24. FUNERAL DIRECTOR Brown Funeral Home		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

708

09/08/2007

2:179.1

1974-1975

1997

1993 991236 147-20714, 11/05/93

priti@lucy.com

Yes.

800-15-145

(Printer, error was introduced in gal)

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 15 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS RFD. # 1, HAGERSTOWN, MARYLAND	
3. NAME OF DECEASED (Type or print) First LOUIS Middle SAM Last DORFMAN		4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1900
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY HOME FURNISHING CO.	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL DORFMAN		14. MOTHER'S MAIDEN NAME EVA VIRSHICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES W.W. I		16. SOCIAL SECURITY NO. 108-07-2328A	
17. INFORMANT MRS. PEARL C. ELLIOTT,		Address ROUTE # 1 HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 17, 1967 , to SEPT. 28, 1967 , that (I) (we) last saw the deceased alive on SEPT. 27, 1968 , and that death occurred at 5:15A M, from causes and on the date stated above			
22a. SIGNATURE DOMINGO A. GARCIA		22b. DATE SIGNED SEPT. 28, 1967	
22c. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA		22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/30/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH.CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEMORANDUM FOR THE DIRECTOR

MEMORANDUM FOR THE DIRECTOR

DATE: 10/1/54

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

RE: [Illegible]

FOR INFORMATION, NEW YORK, 10/1/54

NEW YORK, 10/1/54

[Illegible text]

[Illegible text]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

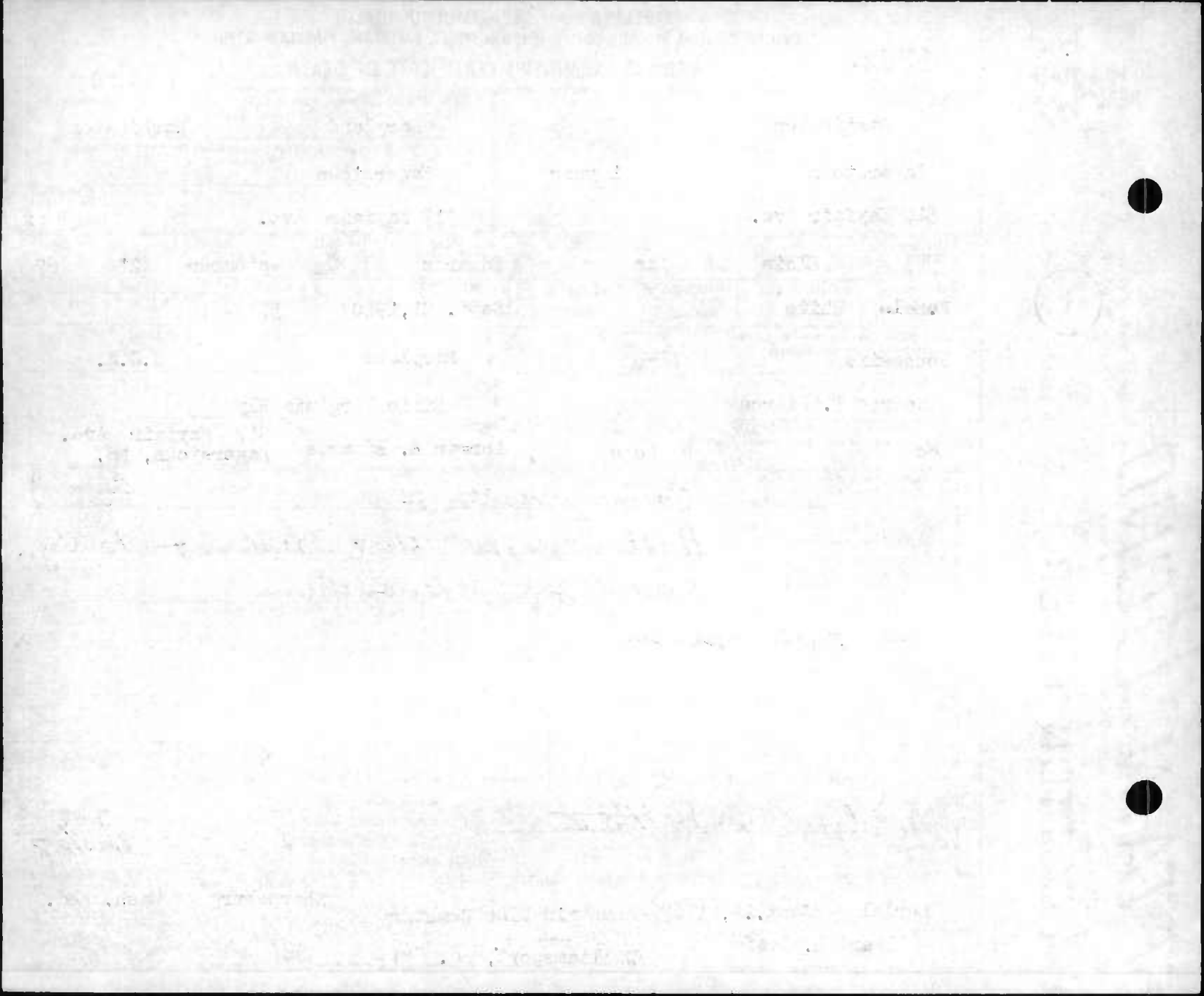
13026

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13030

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN It <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 Mayfair Ave.</u>				d. STREET ADDRESS <u>517 Mayfair Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Mae</u> Last <u>Edwards</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1910</u>		9. AGE (In years lost birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Pierce</u>				14. MOTHER'S MAIDEN NAME <u>Effie Virginia Ely</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Norman E. Edwards</u> <u>517 Mayfair Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart Disease</u> DUE TO <u>10-6 yrs</u> (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10-6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>chr. pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. D. Howard</u> M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>				25. REC'D BY REGISTRAR <u>7 Church St. Williamsport, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

SEP 26 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

10/4/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13027

13031

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 46 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md 012
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Beatrice Last Fazenbaker		4. DATE OF DEATH Month 9 Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1910
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 5 Days 14	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Md. Stom W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Charles Verley	
14. MOTHER'S MAIDEN NAME Lula Coffman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-24-5180		17. INFORMANT W. M. Stab Hosp. Hagerstown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Metastatic Carcinomatosis (b) Carcinoma of bladder DUE TO 1 (c) 1yr		INTERVAL BETWEEN ONSET AND DEATH 1 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8-14 , 19 67 , to 9-29 , 19 67 , that (I) (we) last saw the deceased alive on 9-29 , 19 67 , and that death occurred at 1:25 A M, from causes and on the date stated above	
22a. SIGNATURE Edwin G. Riley		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) Edwin G. Riley		22d. ADDRESS 1500 Pennsylvania Ave. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/67	
23c. NAME OF CEMETERY OR CREMATORY County Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Lillian Beatrice Farnsworth

24 21

Metastatic Carcinoma of Bladder

1 year

Cheney, H. Riley
1200 Pennsylvania Ave.
Washington, D.C.
8-14 8-14 8-14
8-14 8-14 8-14
8-14 8-14 8-14

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13028

13032

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 236 N. Locust St.		d. STREET ADDRESS 236 N. Locust Street	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELIZABETH Last FERREBEE		4. DATE OF DEATH Month Sept. Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1913
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 3 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Clem		14. MOTHER'S MAIDEN NAME Rachael Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-28-2024	
17. INFORMANT Mr. Elwood G. Ferrebee		Address N. Locust St Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour Recent			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Hagerstown, Md.	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DATE SIGNED 9-2-67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 5, 1967	22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
22d. LOCATION (City, town, or county) (State) Williamsport, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles Judge		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR SEP 6 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

10/19/67

13029

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13033

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 60 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md. Route 1 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hos.			d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Luther Fiery JR.			4. DATE OF DEATH Month Day Year Sept. 19 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1879	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer		11. BIRTHPLACE (County & State, or foreign country) Wash. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Luther Fiery Sr.		
14. MOTHER'S MAIDEN NAME Annie Spickler			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		
16. SOCIAL SECURITY NO. 215-36-7160		17. INFORMANT Address Mrs Eva Fiery, Rd. 1, Clear Spring Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Atherosclerosis, General					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 67 , to 9/19 , 19 67 , that (I) (we) last saw the deceased alive on 9/17 , 19 67 , and that death occurred on 9/19 , 19 67 , at Clear Spring, Md. from causes on and on the date stated above.					
22a. SIGNATURE Samuel R. Ryan, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTURO RIEGO		22d. ADDRESS 119 E. Antietam St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/22/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Taber Cemetery	23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.		
24. FUNERAL DIRECTOR Margaret Rowland		ADDRESS Clear Spring, Md.		25a. REC'D BY REGISTRAR SEP 25 1967	25b. REGISTRAR'S SIGNATURE [Signature]

1
FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13030

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13034

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gapland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Geraldine Marie Fraley		4. DATE OF DEATH Month Day Year September 4, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1965
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 10 8	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
12. FATHER'S NAME David L. Fraley		13. MOTHER'S MAIDEN NAME Nancy L. Bowman	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		15. SOCIAL SECURITY NO. None	
16. INFORMANT Mr. David L. Fraley, Gapland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus and fulminating viral gastroenteritis 5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUKE (c) DUKE		INTERVAL BETWEEN ONSET AND DEATH Sev. days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 9/5/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9- 6- 67	
23c. NAME OF CEMETERY OR CREMATORY Bolivar Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Bolivar, West Virginia	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR SEP 7 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13031

CERTIFICATE OF DEATH

13035

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>1 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hosp.</u>				d. STREET ADDRESS <u>323 S. Locust St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Kleewallyn</u> Last <u>FRENCH</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/67</u>	9. AGE (In years last birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u> Hours <u>15</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell L. French</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE WITNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother — Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 1/2 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> , 19 <u>67</u> to <u>9/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/23</u> 19 <u>67</u> , and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Young</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>		22d. ADDRESS <u>Hagerstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery, Hagerstown, Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>			
24. FUNERAL DIRECTOR <u>W. J. Normant, Hagerstown, Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>SEP 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS

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4-21-24

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W 2/4/14

but, it is impossible

W. J. 1941

Russell L. French

2. $\sin^2 \theta = \frac{1}{2}$ $\Rightarrow \theta = \frac{\pi}{4}$ or $\frac{3\pi}{4}$ or $\frac{5\pi}{4}$ or $\frac{7\pi}{4}$

7-10-1919

1994

52

459

674 10/12/2011

Richard A. Young

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13032

13036

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 211 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1761 Jefferson Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Gail Gaver		4. DATE OF DEATH Month Day Year September 30, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1902
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Myersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Gaver		14. MOTHER'S MAIDEN NAME Fannie Shepley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 5-2-21 to 5-4-25		16. SOCIAL SECURITY NO. 705-10-6653	
17. INFORMANT Randall H. Palmer, 3806 Hendon Rd.		18. ADDRESS Randall H. Palmer, 3806 Hendon Rd.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic Cardio. Dis. DUE TO (c) Phenemetic heart dis - Atrial fibrillation. Hx cardiac failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 258 Jan 19 67 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 258 Jan 19 67 to Sept 30, 19 67 , that (I) (we) last saw the deceased alive on Sept 19 67 and that death occurred at 9P M, from causes and on the date stated above. 22a. SIGNATURE Richard T. Binford 22b. DATE SIGNED 2 October 1967 22c. PHYSICIAN'S NAME (Type) 1135 Potomac Avenue Richard T. Binford, M. D. 22d. ADDRESS Binford, M. D.		INTERVAL BETWEEN ONSET AND DEATH 5 to 6 yrs 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-67	
23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Best, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR OCT 4 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

A34 BR
10/19/67

STATEMENT OF DEATH

NAME OF DECEASED CHARLES C. CROFT
AGE 35 SEX M RACE W

DATE OF DEATH 1917 PLACE OF DEATH NEW YORK

CAUSE OF DEATH HEART DISEASE

PLACE OF BIRTH NEW YORK

DATE OF BIRTH 1917

PLACE OF DEATH NEW YORK

DATE OF DEATH 1917

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PLACE OF DEATH NEW YORK

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 3 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COFFMAN HOME FOR AGED		d. STREET ADDRESS 951 EAST MAIN AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MONROE Last GIFFIN		4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 7, 1888
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 21 Days 11 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER		10b. KIND OF BUSINESS OR INDUSTRY LIMESTONE MFG.	
11. BIRTHPLACE (County & State, or foreign country) DARGAN, WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMMANUEL GIFFIN		14. MOTHER'S MAIDEN NAME SARAH JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-10-3860	
17. INFORMANT 709 N. MULBERRY ST. MR. WILLIAM E. GIFFIN, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign prostatic hypertrophy, genital arterial sensitivity.		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (X) physician attended the deceased from Aug 12, 1967 , to Sept 7, 1967 , that (I) (X) last saw the deceased alive on 9/7 1967, and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED SEPT. 9, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III		22d. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/11/67	
23c. NAME OF CEMETERY OR CREMATORY SAMPLES MANOR CEMETERY		23d. LOCATION (City or Town) (County) (State) SHARPSBURG WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR SEP 13 1967 DATE SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

WASHINGTON

DECEASED

DATE OF DEATH

WAS. D. STATE

DATE OF DEATH

DATE OF DEATH

AGE & SEX & RACE

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13034

13038

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 3 1/2 Mos		d. STREET ADDRESS 33 No Locust St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 319 No Cannon Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last GRAMS		4. DATE OF DEATH Month sept Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 31 1876
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonathan Grams		14. MOTHER'S MAIDEN NAME Lydia Tritt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-4213	
17. INFORMANT Lee R. Grams		Address 319 No Cannon Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) marked hypotension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1967 , 19 46 to death , 19 46 , that (I) (we) last saw the deceased alive on 9-13-67 , 19 46 , and that death occurred at 4:20 M, from causes and on the date stated above.			
22a. SIGNATURE Francisco E. Rosillo		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) Francisco E. Rosillo, M. D.		22d. ADDRESS 580 Northern Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/67	
23c. NAME OF CEMETERY OR CREMATORY Locust valley Cem		23d. LOCATION (City or Town) (County) (State) Locust Valley Fred Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

WARRANT FOR THE ARREST OF
JAMES EARL RAY

TESTIMONY OF DEATH

Washington

U. S. District Court

212 E. Cannon Ave

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CHURCH

AGE 31

WHITE

INTERVIEWED

INTERVIEWED

1968

1968

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AGE 31

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13035

13039

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cecil Sigler Haines				4. DATE OF DEATH Month Day Year September 17, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1892	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 3 12		IF UNDER 24 HRS. Hours Min. 3 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & R. R. Emp.		10b. KIND OF BUSINESS OR INDUSTRY Clerk Farming & Store Rm.		11. BIRTHPLACE (County & State, or foreign country) Findlay, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles W. Haines				14. MOTHER'S MAIDEN NAME Sarah A. Mc Bride			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 212-24-5671		17. INFORMANT Address Mrs. Myrtle A. L. Haines, Brownsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X Sepsicemia DUE TO (b) Acute nephritis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) suppression of urine						INTERVAL BETWEEN ONSET AND DEATH 10 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 5, 1967 to Sept 17, 1967 , that (I) (we) last saw the deceased alive on Sept 17, 1967 , and that death occurred at 11 M, from causes and on the date stated above.							
22a. SIGNATURE W. W. Haines				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 19, 1967	
22c. PHYSICIAN'S NAME (Type) W. W. Haines				22d. ADDRESS Brownsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-67		23c. NAME OF CEMETERY OR CREMATORY Brownsville Heights Cem.		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13036

13040

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield	
c. LENGTH OF STAY in 1b Life		d. STREET ADDRESS 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nona Middle May Last Happel		4. DATE OF DEATH Month Sept. Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1884
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	11. IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cascade, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Kettoman		14. MOTHER'S MAIDEN NAME Carrie B. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT G. Fred Happel,		Address Highfield Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardiac decompensation, acute DUE TO (c) 1-2 wks		INTERVAL BETWEEN ONSET AND DEATH 9-10 AM	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-15 , 19 67 , to 9-25 , 19 67 , that (I) (we) last saw the deceased alive on 9-20 19 67 , and that death occurred at 3:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Harry H. Youngs Jr		22b. DATE SIGNED 9-28-67	
22c. PHYSICIAN'S NAME (Type) Harry H. Youngs Jr		22d. ADDRESS Blue Ridge Summit Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/67	
23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Lantz #1 Frederick Md.	
24. FUNERAL DIRECTOR Valter J. Groe		25a. REC'D BY REGISTRAR SEP 29 1967	
ADDRESS Waynesboro Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10/19/67

UNITED STATES DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION

CERTIFICATE OF DEATH

Washington

Washington

1919

1919

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1919

1919

George W. Jackson
Born 1919
Died 1919
Cause of death
Place of death

George W. Jackson
Born 1919
Died 1919
Cause of death
Place of death

George W. Jackson
Born 1919
Died 1919
Cause of death
Place of death

George W. Jackson
Born 1919
Died 1919
Cause of death
Place of death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 36 E. Washington St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GROVER LEON HARPER		4. DATE OF DEATH Month Day Year Sept. 11 1967 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19 1905
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Md Hagerstown Wash Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lee Harper		14. MOTHER'S MAIDEN NAME Leah Semler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO. 217-28-7261	
17. INFORMANT Mrs Oressie Carter		Address 36 E. Wash St Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, RIGHT UPPER LOBE BRONCHUS DUE TO WITH EXTENSION INTO MIDDLE LOBE BRONCHUS AND PERIHILAR TISSUES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PERIHILAR TISSUES. (c) pleura		INTERVAL BETWEEN ONSET AND DEATH 11 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic involvement of mediastinal lymph nodes, pericardium, right pleura		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY *Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/26, 19 66 to 9/11, 19 67 , that (I) (we) last saw the deceased alive on 9/10 19 67 , and that death occurred at 1:45M , from causes and on the date stated above.			
22a. SIGNATURE A. Mandell		22b. DATE SIGNED 9/11/67	
22c. PHYSICIAN'S NAME (Type) A. Mandell, M.D.		22d. ADDRESS 301 E. Antietam St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem Park	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

STATEMENT OF WORK

1. The purpose of this statement is to define the work to be performed by the contractor under the contract.

2. The work shall be performed in accordance with the specifications and drawings attached hereto.

3. The contractor shall be responsible for the design, construction, and installation of the equipment.



4. The contractor shall be responsible for the maintenance and repair of the equipment.

5. The contractor shall be responsible for the training of personnel in the use of the equipment.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G393 10/3/67 ph

13038

CERTIFICATE OF DEATH

13042

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md.		c. LENGTH OF STAY IN 1b 26 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 Residence		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) First Annie Middle Hart Last Hart		4. DATE OF DEATH Month Sept. Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 Oct. 15, 1889
9. AGE (In years lost birthday) yrs. 89		10. IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson W. Widmyer		14. MOTHER'S MAIDEN NAME Rebecca Faulkwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Orville Ernst		Address Big Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Chronic glomerulonephritis DUE TO General arteriosclerosis DUE TO General arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-30, 1967 to 9-23, 1967 , that (I) (we) last saw the deceased alive on 9-15, 1967 , and that death occurred at 10:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE F. E. Rosillo, M. D.		22b. DATE SIGNED 9-25-67	
22c. PHYSICIAN'S NAME (Type) F. E. Rosillo, M. D.		22d. ADDRESS Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.	
24. FUNERAL DIRECTOR Margaret Rowland		25a. RECORD BY REGISTRAR SEP 27 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE SEP 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

REPORT OF THE
COMMISSIONER OF HEALTH
ON THE
PROGRESS OF THE
BUREAU OF VETERINARY MEDICINE
DURING THE
YEAR 1907

Presented to the
HOUSE OF REPRESENTATIVES
IN SENATE AND HOUSE
COMMITTEE ON AGRICULTURE
AND FORESTRY
AT THE ANNUAL MEETING
Held at the
Capitol Building
Washington, D. C.
January 15, 1908

By
J. C. LUDWIG, M. D., V. M.
Commissioner of Health

Published by
the Government Printing Office
Washington, D. C.
1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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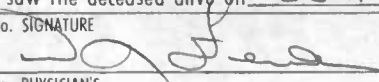
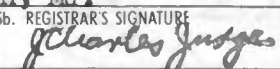
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13043

13039

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b 27 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 20 Snyder Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marie Irene Hartman				4. DATE OF DEATH Month Day Year September 23, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1914	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 8 18		11. BIRTHPLACE (County & State, or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Funkstown, Md.	
13. FATHER'S NAME Joseph W. Hartman				14. MOTHER'S MAIDEN NAME Mary E. Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT Hartman Hagerstown, Md. Mrs. Mary E. Clark, 20 Snyder Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF RECTO-SIGMOID DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 Dec. , 1967, to 23 Sept. , 1967, that (I) (we) last saw the deceased alive on 23 Sept. , 1967, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 25 Sept. 1967		22c. PHYSICIAN'S NAME (Type) W.N. FENDER	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-67		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City or Town) (County) (State) Funkstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR SEP 27 1967		25b. REGISTRAR'S SIGNATURE 	

STATE OF TEXAS

IN SENATE,
January 10, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 76 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1524 Sherman Ave.					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1524 Sherman Ave.				
3. NAME OF DECEASED (Type or print) Joseph Glenn Hellane			4. DATE OF DEATH September 2, 1967		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8-7-91 9. AGE (in years last birthday) 76 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk 10b. KIND OF BUSINESS OR INDUSTRY railroad			11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John T. Hellane			14. MOTHER'S MAIDEN NAME Julia B. Brady						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 705-10-6221		17. INFORMANT Mrs. Ruth Hellane, Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) Severe Hypertensive Cardio Vascular Disease. Several years (c)								INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1965, to Sept. 2, 1967, that (I) (we) last saw the deceased alive on May 10, 1967, and that death occurred at 10 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>			22b. DATE SIGNED 9-5-67		22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				
22d. ADDRESS Hagerstown, Md.			22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-6-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.			25a. REC'D BY REGISTRAR SEP 8 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13041					13045				
1									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS RFD 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy			First Daisy Middle Maudie Last Hopp		4. DATE OF DEATH Month September Day 21 Year 1967				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-87		9. AGE (in years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY baby sitter		11. BIRTHPLACE (County & State, or foreign country) Leitersburg, Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Lowman					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-28-2803		17. INFORMANT Mrs. Talba Barnes, Hagerstown Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus. 4331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arricular Fibrillation (c) Antenatal - Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None 19. INTERVAL BETWEEN ONSET AND DEATH 5 min. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 17, 1967 to Sept 21, 1967 , that (I) (we) last saw the deceased alive on Sept 4, 1967 , and that death occurred at 7:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 22, 1967		
22c. PHYSICIAN'S NAME (Type) J.H. Beachley					22d. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-25-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR SEP 26 1967		25b. REGISTRAR'S SIGNATURE [Signature]		

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Memorandum

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

Re New York letter to Bureau dated 1/15/64.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being prepared by the New York Office.

Very truly yours,
[Illegible Signature]

John J. [Illegible]

Enclosure

1-15-64

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #9 Film #G392 9/21/67 ph									
13042 CERTIFICATE OF DEATH 13046									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 4 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL					d. STREET ADDRESS 55 East Franklin St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle ESTHER Last HOVIS					4. DATE OF DEATH Month SEPT Day 13 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/8/95		9. AGE (In years lost birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Watson					14. MOTHER'S MAIDEN NAME Ella Golden				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. A 418-38-1557		17. INFORMANT Address Mr J. Maurice Hutzell 105 Broadway Hagerstown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO TERMINAL CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA RECTUM (c) UNKNOWN								INTERVAL BETWEEN ONSET AND DEATH MAY 1967 UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/15/67 , 19 67 , to 9/13 , 19 67 , that (I) (we) last saw the deceased alive on 9/13 , 19 67 , and that death occurred at 1:02 PM , from causes and on the date stated above									
22a. SIGNATURE Francisco G. Japzon M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 9/13/67	
22c. PHYSICIAN'S NAME (Type) FRANKISCO G. JAPZON					22d. ADDRESS WESTERN MD. STATE HOSP. HAGERSTOWN, MARYLAND 21740				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or town) (County) (State) Hagerstown Wash Co Md		
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc					25a. RECEIVED BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

1962
STATE OF DEATH
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Date of Birth: [illegible]
Date of Death: [illegible]
Cause of Death: [illegible]
Place of Death: [illegible]
Signature: [illegible]
Witness: [illegible]
Registrar: [illegible]
Date: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13043

13047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>4 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>3201 Landover St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Edwin</u> Last <u>Humphrey</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1914</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Salt Lake City, Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George S. Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Florence Opal Noon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-6792</u>	
17. INFORMANT <u>Mrs. A. E. Humphrey</u>		Address <u>Alexandria, Va.</u> <u>3201 Landover St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo + 7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> , 19 <u>67</u> , to <u>SEP 23</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>SEP 23</u> 19 <u>67</u> , and that death occurred at <u>5 A. M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles A. Hoffman</u>		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Potomac St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/26/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hest</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>	

(M)

EXTRACT OF DEATH

THE CITY OF NEW YORK, DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS, OFFICE OF THE REGISTRAR, NEW YORK, N.Y.

NAME

RESIDENCE

DATE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

TIME

PLACE

AGE

NAME OF DECEASED

DATE

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE

TIME

PLACE

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13048

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in lb 7 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 214 West Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josiah Middle Worthington Last Jamison		4. DATE OF DEATH Month Sept. Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 11 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Jamison		14. MOTHER'S MAIDEN NAME Mary Crampton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9609	
17. INFORMANT Mrs. Martha Grove		Address Sharpsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerosis cardiovascular disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dislocated left shoulder and fractured ribs.			INTERVAL BETWEEN ONSET AND DEATH 11rs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell from bed at home.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7/6 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sharpsburg Wash. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks, M. D.		DATE SIGNED 9/5/67	
EXAMINER'S NAME (Type) Howard N. Weeks, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 6, 1967	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg, Maryland
23. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport, Maryland.	
24a. REC'D BY REGISTRAR SEP 7 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

THE STATE OF TEXAS
COUNTY OF DALLAS

1

2

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 1st day of January, 1901.

Notary Public for Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13045

CERTIFICATE OF DEATH

13049

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 264 S. POTOMAC ST.	
3. NAME OF DECEASED (Type or print) First MAUDE Middle AMANDA Last KERSHNER		4. DATE OF DEATH Month SEPTEMBER Day 12 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1887
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES OLIVER BUTTS		14. MOTHER'S MAIDEN NAME ELLA SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, NO known) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HELEN KARN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease with congestive heart failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. , 19 67 , to 9/12/ , 19 67 , that (I) (we) last saw the deceased alive on 9/12/67 19 67 , and that death occurred at 6:30 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>Charles C. Spencer</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Charles C. Spencer		22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 18 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

STATEMENT OF

DATE

NAME

AGE

ADDRESS

CITY

STATE

DATE OF BIRTH

DATE OF DEATH

DATE OF INTERVIEW

INTERVIEWER

DATE OF BIRTH

DATE OF DEATH

DATE OF INTERVIEW

INTERVIEWER

DATE OF BIRTH

DATE OF DEATH

DATE OF INTERVIEW

INTERVIEWER

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13046

13050

1. PLACE OF DEATH e. COUNTY <i>Washington</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown - Ind.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gambills, Ind.</i> 02-2			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>WESTERN MD STATE HOSPITAL</i>				d. STREET ADDRESS <i>Shelburne Highway</i>			
3. NAME OF DECEASED (Type or print) <i>Robert Michael Kolbe</i>				4. DATE OF DEATH <i>9 4 1967</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 24, 1959</i>	
9. AGE (In years last birth day) <i>7</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Francis W. Kolbe</i>				14. MOTHER'S MAIDEN NAME <i>Margaret L. Windsor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Francis W. Kolbe</i> Address <i>Gambills, Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Lobular pneumonia</i> <i>355X</i> DUE TO (b) <i>Brain damage</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>2d</i> <i>9 mon</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-10 1967</i> to <i>9-4 1967</i> , that (I) (we) last saw the deceased alive on <i>9-4 1967</i> , and that death occurred at <i>3:55 PM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Edwin G. Riley</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>9-4-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>EDWIN G. RILEY</i>				22d. ADDRESS <i>Hagerstown, Ind.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 7, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Colmar Manor, Pro Geo Md.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR <i>SEP 8 1967</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 900 Frederick St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward William Kuhlman			4. DATE OF DEATH Sept. 25, 1967		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-9-09 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) police sgt. 10b. KIND OF BUSINESS OR INDUSTRY City police			11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Edward T. Kuhlman			14. MOTHER'S MAIDEN NAME Leona Rowland						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-09-1131		17. INFORMANT Mrs. Catherine Kuhlman, Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 min 6 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-17-60, 19, to 9-11-67, 19, that (I) (we) last saw the deceased alive on 9/11/67 19, and that death occurred at 11:05 PM, from the causes and on the date stated above.									
22a. SIGNATURE Robert V. H. Campbell M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9/26/67			
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell			22d. ADDRESS Hagerstown Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-28-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.			ADDRESS		25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>		

WASHINGTON COUNTY JAIL
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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10/19/67

13048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13052

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN b Minutes			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick				10.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rfd. 5			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Silas Daniel Kuhn, Jr.				4. DATE OF DEATH Month Day Year September 26, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1933	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days 5 25	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Mapleville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Silas D. Kuhn				14. MOTHER'S MAIDEN NAME Beulah Hoffmaster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 4 May 53- 15 Apr. 55				16. SOCIAL SECURITY NO. 220-30-9474		17. INFORMANT Mrs. Patsy M. Kuhn, Frederick Rfd. 5, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of skull and laceration of brain 916.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Welding with torch causing explosion of oil drum						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Welding with torch causing explosion of oil drum					
20c. TIME OF INJURY Hour 7:00 p.m. Month, Day, Year 9/26 1967	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Rt. (County) (State) Keedysville, 1 Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.					
EXAMINER'S NAME (Type)		22. DATE SIGNED 9/27/67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9- 29- 67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR OCT 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES

DEPARTMENT OF PHYSICS

PHYSICS 101

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12 1
13049

CERTIFICATE OF DEATH

13053

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 602 Brighton Place	
3. NAME OF DECEASED (Type or print) ROMAN JOSEPH LACHOTTA		4. DATE OF DEATH Sept 1 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2 1912
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Mack Truck	
11. BIRTHPLACE (County & State, or foreign country) Kattowitz Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-34-1112	
17. INFORMANT Mrs Mary Lachotta		Address 602 Brighton Pl	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Uentricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion (c) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 10 min 15 min 60 Ks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 p.m. 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1967 to 9-1, 1967 , that (II) (we) last saw the deceased alive on 8-31 19 67 , and that death occurred at 5:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE M.E. Byrkit		22b. DATE SIGNED 9-3-67	
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit		22d. ADDRESS Williamsport Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/4/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem Park		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

WASHINGTON, D.C.

1945

THE WHITE HOUSE, WASHINGTON, D.C.

MEMORANDUM FOR THE PRESIDENT

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

Very truly yours,

[Illegible Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13050

CERTIFICATE OF DEATH

13054

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 16 Mos			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Manor Nursing Home				d. STREET ADDRESS 921 A Main Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE WATKINS LEATHERMAN				4. DATE OF DEATH Month Day Year Sept 12 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5 1900	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) W. VA.		CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-1900		17. INFORMANT Address Mrs Arlene Higgins 1388 Salem Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V Disease DUE TO (c) Unph						INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CNS symptoms with neurogenic bladder						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 8, 1963 , to Sept 12, 1967 , that (I) (we) last saw the deceased alive on Sept 12, 1967 , and that death occurred at 9:31 PM , from causes and on the date stated above.							
22a. SIGNATURE L. L. Packer Jr M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/13/67	
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr				22d. ADDRESS 145 W. Washington St Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown Md				25a. REC'D BY REGISTRAR DATE SEP 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
26. Andrew K. Coffman Funeral Home Inc							

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ASTOR LENOX TILDEN FOUNDATION

455 FIFTH AVENUE

NEW YORK 17, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS R DUTE # 1	
3. NAME OF DECEASED (Type or print) NEIL RUDY LEATHERMAN		4. DATE OF DEATH 9 12 19 67	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/67
9. AGE (In years lost birthday) 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PAUL CECIL LEATHERMAN		14. MOTHER'S MAIDEN NAME MARILYN LAMBERT RUDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PAUL C. LEATHERMAN		Address Myersville Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to interference DUE TO (b) Respiratory distress syndrome DUE TO (c) Immaturity -			INTERVAL BETWEEN ONSET AND DEATH 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/12/67 , 19__ to 9/12/67 , 19__, that (I) (we) last saw the deceased alive on 9/12/67 , 19__, and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE Harold Hyatt		22b. DATE SIGNED 13 SEP 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept 14, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. MARK'S	23d. LOCATION (City or Town) (County) (State) Myersville Fred Md
24. FUNERAL DIRECTOR BITTLE FUNERAL Home MYERSVILLE		25. REC'D BY REGISTRAR SEP 18 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

REPORT ON EXAMINATION OF THE
CORPSE OF DEATH

W. B. RAY AND F. B. DICK
MURKSVILLE

WASHINGTON
HAGERSTOWN

WASHINGTON COUNTY HOSPITAL ROUTE #1

NEIL RUDY LEATHERMAN
M WHITE
P 12/12/67
67
10

PAUL CECIL LEATHERMAN MARILYN LAMBERT RUDY

*Reported by Dr. J. H. [illegible]
[illegible]*

12/12/67

Harold [illegible]

MARYLAND

BITTLE FUNERAL HOME MURKSVILLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13052

CERTIFICATE OF DEATH

13056

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>R # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Lowman</u> 11		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1962</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Edward Lowman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Otzelberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>J.E. Lowman</u>		Address <u>R # 1 Sharpsburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>057.1 Meningococcemia</u> DUE TO (b) <u>Waterhouse-Friderichsen Syndrome</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> , 19 <u>67</u> , to <u>9/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> 19 <u>67</u> , and that death occurred at <u>12:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Young</u>		22b. DATE SIGNED <u>9/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown - Washington-Md</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

10-11-1963

1030 • J. Neurosci., June 23, 2010 • 30(25):1025–1032

5091-1-205

10. The following table shows the number of people who attended the concert in each age group.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

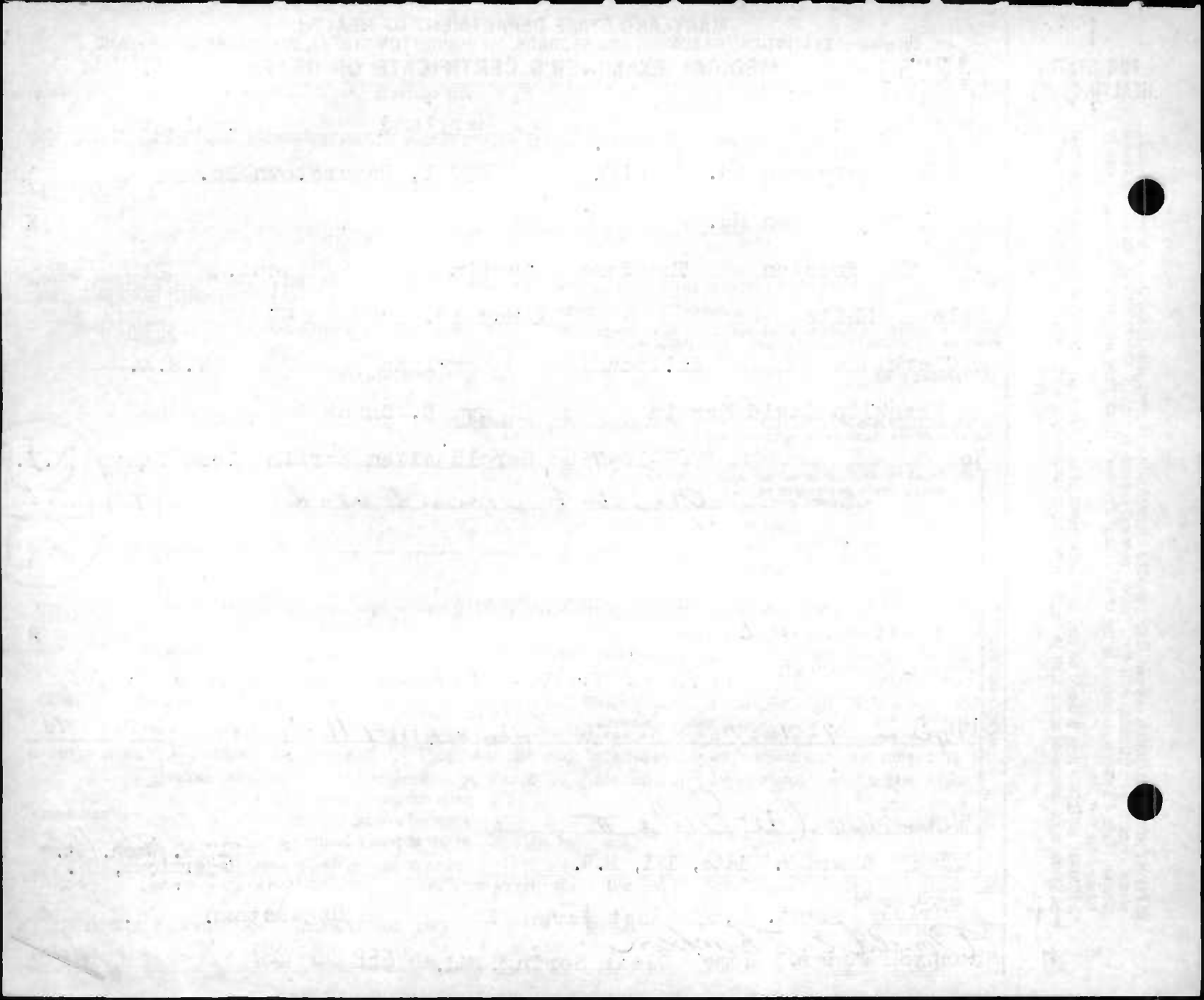
13053

13057

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD1 Hagerstown Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD1 Hagerstown Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 1, Hagerstown Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Preston Theodore Martin				4. DATE OF DEATH Month Day Year Sept. 21 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1908		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin David Martin				14. MOTHER'S MAIDEN NAME Eva L. Shank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-7506		17. INFORMANT Harold Allen Martin Long Island N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gunshot wound head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Placed shotgun between eyes - Pulled trigger					
20c. TIME OF INJURY Hour a.m. p.m. 9-21 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home - RFD1 Hagerstown		20f. (City or town) (County) (State) Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, III				22. DATE SIGNED 217 W. Wash. 2/26/67			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR Donald E. Thompson				25a. REC'D BY REGISTRAR SEP 26 1967			
Address Thompson Funeral Home Clear Spring, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 3 WKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK MD				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 142 W. HIGH ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle E Last MASON					4. DATE OF DEATH Month 9 Day 6 Year 19 67				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10.30.1882		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME THOMAS BOOTMAN					14. MOTHER'S MAIDEN NAME SADIE TRUXELL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216.54.8404		17. INFORMANT Address BEVERLY B MASON HANCOCK MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus (probable) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture L. hip 5 yrs. ago - more or less b'd confined since -									INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 8-19, 1967 , to 9-6, 1967 , that (I) (we) last saw the deceased alive on 9-5, 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above.									
22a. SIGNATURE John H. Hornbaker					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-8-67		
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.					22d. ADDRESS 154 West Washington St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9.8.67		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS EPISCOPAL		23d. LOCATION (City or Town) (County) (State) HANCOCK WASHINGTON MD.			
24. FUNERAL DIRECTOR ADDRESS Howard F. Stone Hagerstown Md					25a. REC'D BY REGISTRAR DATE SEP 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

WASHINGTON COUNTY, MISSOURI

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WASHINGTON

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WASHINGTON COUNTY, MISSOURI

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WASHINGTON COUNTY, MISSOURI

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VR A15 (4)
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13055					13059						
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1108 Pope Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Richard Lane McGowan					4. DATE OF DEATH Month Sept. 2, Day 19 Year 67						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-67		9. AGE (In years last birthday) — yrs. 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles McGowan					14. MOTHER'S MAIDEN NAME Constance Poffenberger						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. none		17. INFORMANT Charles McGowan, Hagerstown, Md. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 67 to 9/2 , 19 67 , that (I) (we) last saw the deceased alive on 9/2 , 19 67 , and that death occurred at 4:30 PM from the causes and on the date stated above.											
22a. SIGNATURE Ronald E Keyser				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-2-67					
22c. PHYSICIAN'S NAME (Type) RONALD E. KEYSER				22d. ADDRESS 119 KING ST. HAGERSTOWN							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.				
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

7-257573

St. Louis County Hospital

Edward Lane

St. Louis, Mo.

Charles Bowman

None

1912

St. Louis County Hospital

St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13056 CERTIFICATE OF DEATH 13060											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY IN ID <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, St. James Village, Hagerstown 211</u> d. STREET ADDRESS <u>Kent Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Harry</u> First Middle Last <u>Glenville</u> <u>Mellott</u>			4. DATE OF DEATH <u>September 16, 1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
8. DATE OF BIRTH <u>April 27, 1888</u>			9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR <u>4</u> Months <u>19</u> Days		IF UNDER 24 HRS. <u>19</u> Hours <u>19</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hydro-operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Electric- P. E.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clearfield, Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lemuel Gordon Mellott</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Litton</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>217-10-9040</u>		17. INFORMANT <u>Marvin E. Mellott</u>			Address <u>Kent Ave.. St. James Village Hagerstown, Md. R.F.D 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, Abscess large Bowel due to diverticulosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Sept 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 17</u> , 19 <u>67</u> , and that death occurred at <u>3:50 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert V. H. Campbell</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/18/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>					22d. ADDRESS <u>Hagerstown Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 19 '67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Williamsport, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Albert L. Leaf, 7 Church St. Williamsport, Md.</u>					25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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General and Antisocial

Political, Economic and Social

Robert V. Campbell
Sept 11 1911
Hogentown Wm
Sept 11 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>60 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>316 Westside Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>(NMN)</u> Last <u>Meyers</u>		4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Abraham Meyers</u>	
14. MOTHER'S MAIDEN NAME <u>18444/ Lena Klavan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-09-3441A</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Mary Meyers 316 Westside Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>High blood pressure, V.I. hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>66</u> , to <u>Sept 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>67</u> , and that death occurred at <u>9:00 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.R. Landis M.D.</u>		22d. ADDRESS <u>311 W. 10th St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington Md</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horne</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DEPARTMENT OF DEATH

Washington

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Washington

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Washington

Washington County Hospital

Washington County

Journal (N.Y.)

Journal

Nov. 14, 1901

Nov. 14, 1901

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia - Nov. 14, 1901

Wm. C. Hoot

Philadelphia

Philadelphia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13058						13062					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Washington						a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
c. LENGTH OF STAY IN 1b life						d. STREET ADDRESS 420 W. Franklin St.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First EDNA Middle PEARL Last MILLER						Month Sept. Day 25 Year 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
female		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug 19, 1894		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bailey						14. MOTHER'S MAIDEN NAME Ida B. McCurdy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Betty Miller				Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease DUE TO (c) Several years										INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to Sept. 25, 1967 , that (I) (we) last saw the deceased alive on Sept. 25, 1967 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr. E. W. Ditto, Jr.</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.						22d. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/28/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home						ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

STATE OF TEXAS

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

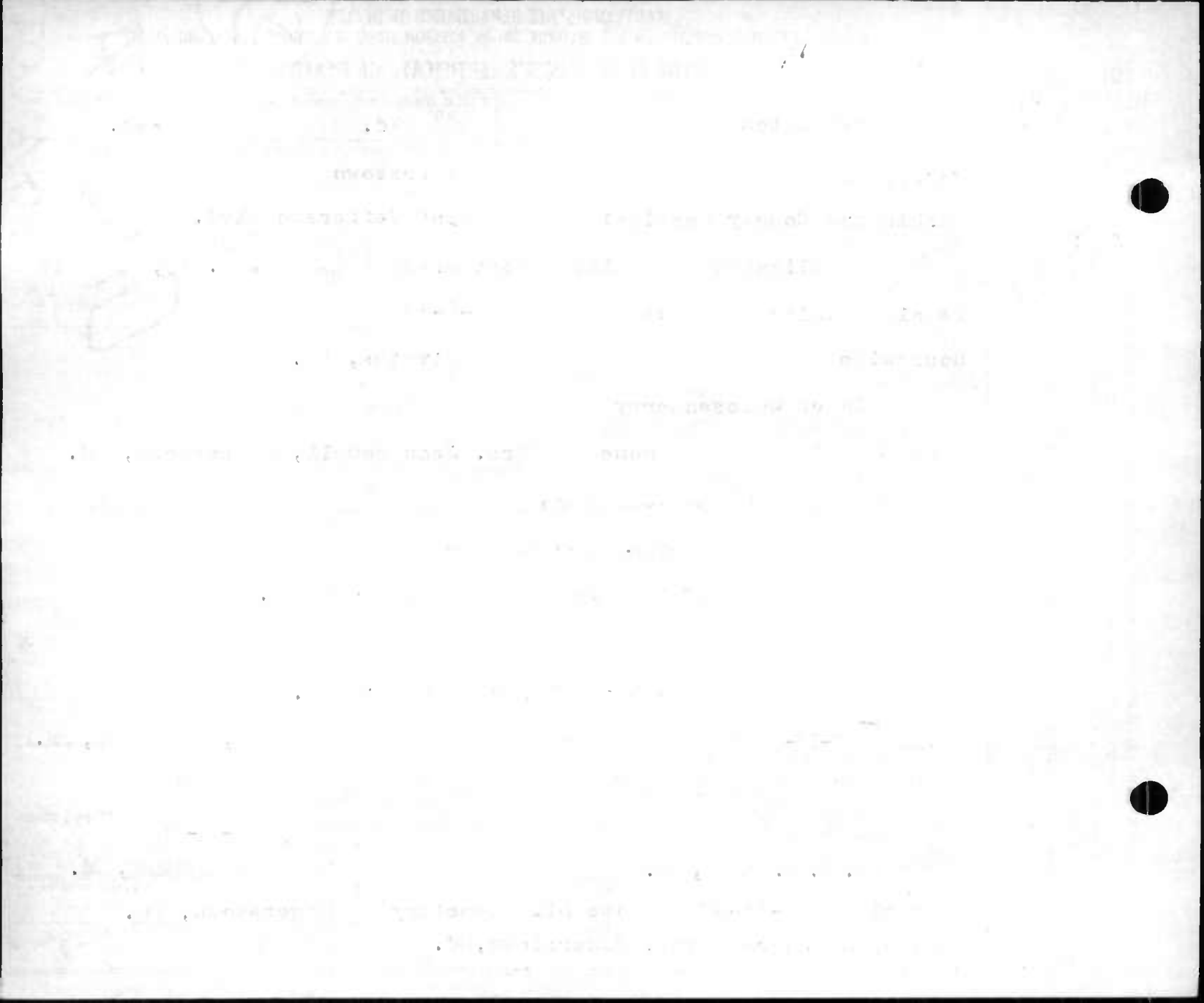
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13063

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1965 Jefferson Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ellen Last Montgomery		4. DATE OF DEATH Month Sept. Day 19, Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-73
9. AGE (In years last birthday) 94		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Sylvatus, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Queesenberry		14. MOTHER'S MAIDEN NAME Sarah Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Jean Nowell, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO 9000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Of Right Femur DUE TO (c) Multiple Lacerations Of Scalp And Face.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down cellar steps at her home.	
20c. TIME OF INJURY Month, Day, Year Hour 9:50 p.m. 9-18-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown, Washington, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. W. Ditto, Jr. EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 9-20-67 Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-21-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown, Md. (County) (State)	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 22 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13060

13064

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berkeley Springs, W. Va.</u> <u>85.3</u>	
c. LENGTH OF STAY IN 1b <u>1 Month</u>		d. STREET ADDRESS <u>Sir Johns Run</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillie Mae Morris</u>		4. DATE OF DEATH <u>Sept. 30, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1901</u> <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9. AGE (In years last birthday) <u>7</u> Months <u>19</u> Days
11. BIRTHPLACE (County & State, or foreign country) <u>Monroe, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Sorrells</u>		14. MOTHER'S MAIDEN NAME <u>Josephine B. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-38-4406-A</u>	
17. INFORMANT <u>Wellburn J. Morris, Berkeley Springs,</u>		Address <u>W. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bilateral pulmonary embolism</u> 609X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Recent Surgery - Left pyelostomy</u> (c) <u>Solitary left kidney with ureteral obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours.</u> <u>2 1/2 weeks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 29, 1967</u> to <u>Sept 30, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 29, 1967</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Jos. Calvin Crisp</u> M.D.		22b. DATE SIGNED <u>Oct 4 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jos Calvin Crisp</u>		22d. ADDRESS <u>580 Northern Ave. Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/3/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson Funeral Home Berkeley Spgs. W.</u>		25a. REC'D BY REGISTRAR <u>OCT 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FROM THE UNIVERSITY OF CALIFORNIA, BERKELEY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13061

CERTIFICATE OF DEATH

13065

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED Twin II (Type or print) First JACK Middle N.M.N. Last NAVE		4. DATE OF DEATH SEPTEMBER 13 1967 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) MARYLAND - WASHINGTON COUNTY	
13. FATHER'S NAME LESTER ALBERTUS NAVE		14. MOTHER'S MAIDEN NAME KATHRYN ALICE BARKDOLL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ROUTE 1 FAIR PLAY MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Atelectasis of Lungs DUE TO (c) Premature Delivery - 6 mos.		INTERVAL BETWEEN ONSET AND DEATH 0 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature Rupture Membranes - 6 mos		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-13 1967 to 9-13 1967 , that (I) (we) lost the deceased alive on 9-13 1967 , and that death occurred at 9:20 PM , from causes and on the date stated above.			
22a. SIGNATURE J. F. Waddill		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) J. F. WADDILL M.D.		22d. ADDRESS HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF SEPT. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON COUNTY HOSPITAL HAGERSTOWN, MARYLAND	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Edwards, Carl. Edm.		25a. REC'D BY REGISTRAR SEP 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Copyright © 1994 by the American Psychological Association

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HAERKSTOWN, NEW JERSEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Infor. taken from birth certificate

13062

CERTIFICATE OF DEATH

13066

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Twin I PAUL Middle NMN Last NAVE				4. DATE OF DEATH Month SEPTEMBER Day 13 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-67	
9. AGE (In years last birthday) 1 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND-WASHINGTON County	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME LESTER ALBERTUS NAVE		14. MOTHER'S MAIDEN NAME KATHRYN ALICE BARK DOLL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Route 1 FAIRPLAY MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Atelectasis of Lungs DUE TO (c) Premature Delivery - 6 mos		INTERVAL BETWEEN ONSET AND DEATH 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature Rupture Membranes - 6 mos		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-13-67, 1967 to 9-13, 1967 , that (I) (we) last saw the deceased alive on 9-13, 1967 , and that death occurred at 8:55 AM , from causes and on the date stated above.							
22a. SIGNATURE J. F. Waddill				22b. DATE SIGNED 9-14-67		22c. PHYSICIAN'S NAME (Type) J. F. WADDILL M.D.	
22d. ADDRESS HAGERSTOWN MARYLAND				23a. BURIAL, CREMATION, REMOVAL (Specify) SEPT. 18, 1967		23b. DATE THEREOF WASHINGTON COUNTY HOSPITAL HAGERSTOWN, MARYLAND	
23c. NAME OF CEMETERY OR CREMATORY SEP. 26 1967				23d. LOCATION (City or Town) (County) (State) Charles Judge		23e. REGISTRAR'S SIGNATURE	
23f. REGISTRAR'S SIGNATURE Charles Judge				23g. REGISTRAR'S SIGNATURE		23h. REGISTRAR'S SIGNATURE	

7-2526601

TO DIRECTOR OF BUREAU OF INVESTIGATION
 FEDERAL BUREAU OF INVESTIGATION
 U. S. DEPARTMENT OF JUSTICE
 WASHINGTON, D. C. 20535

3-WADSWORTH MD.

HAGERSTOWN MARYLAND

1X (unclassified)

X

8-14-61

8-13

44-387-17

8-13

Promote Captain Henderson - 6 mos

Promote Delivery - 6 mos

Comptroller Administration of Funds

Annex

Route 1 Fairplay Maryland

LESTER ALBERTUS HANE

KATHRYN PRICE BARK DOLL

MARYLAND WINCHESTER

MADE WHITE

9-13-61

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PAUL

WAVE

September 13 61

Washington and County Highways

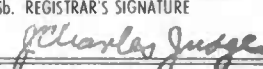
Page 2 of 2

Washington and County Highways

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13063									
CERTIFICATE OF DEATH									
13067									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 31 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 202 E. FRANKLIN ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA BLANCHE NEAL			4. DATE OF DEATH Month Day Year SEPTEMBER 8 1967						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/1897		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN W.R. MINER					14. MOTHER'S MAIDEN NAME IDA BAKER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. HELEN SHUBERT Address HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs. Yes.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 Aug , 19 67 , to 8 Sept , 19 67 , that (I) (we) last saw the deceased alive on 8 Sept 19 67 , and that death occurred at 2:40 P.M. from causes and on the date stated above.									
22a. SIGNATURE 					22b. DATE SIGNED 9 Sept. 67			22c. PHYSICIAN'S NAME (Type) W.N. FENDER	
22d. ADDRESS 218 N. Pennine St., Hagerstown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/11/67		23c. NAME OF CEMETERY OR CREMATORY LEITERSBURG LUTHERN CEM.			23d. LOCATION (City or Town) (County) (State) LEITERSBURG MD.		
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md					25a. REC'D BY REGISTRAR DATE SEP 13 1967		25b. REGISTRAR'S SIGNATURE 		

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VR A15 (4)
25M 1/67

13064 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13068

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 1 yr 5 mo		d. STREET ADDRESS 132 E. Washington St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney - Keedy Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Zella Middle M. Last Newcomer		4. DATE OF DEATH Month Sept. Day 30 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1887
9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Newcomer		14. MOTHER'S MAIDEN NAME Mary M. Garver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-30-980A	
17. INFORMANT Harold L. Newcomer		Address Tacoma Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mediastinal Abscess. DUE TO (c) Esophageal Perforation.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Merct. , 19 64 to SEPT-30 , 19 67 that (I) (we) last saw the deceased alive on SEPT-30 19 67 , and that death occurred about M, from causes and on the date stated above.			
22a. SIGNATURE Charles A. Hoffner M.D.		22b. DATE SIGNED 10/2/67	
22c. PHYSICIAN'S NAME (Type) 2102 A Hoffner		22d. ADDRESS 214 N. Potomac St. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/1967	23c. NAME OF CEMETERY OR CREMATORY Green Hill	23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.
24. FUNERAL DIRECTOR Walter J. Goss		25a. REC'D BY REGISTRAR Waynesboro, Penna.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 4 1967	

STATE OF NEW YORK

County of Hamilton

City of Albany

192 E. Washington St.

Albany, N.Y.

May 23, 1967

Washington Co., N.Y.

May 1, 1967

200-30-222, Harold J. Hancock, Tarrytown, N.Y.

Green Hill, New York, New York


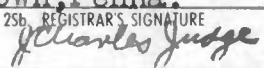
Albany, New York

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13065

13069

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 d. STREET ADDRESS Garis Shop Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD LLOYD NICHOLS Sr First Middle Last 4. DATE OF DEATH sept 12 1967 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept 17 1935 9. AGE (In years last birthday) 31 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker 10b. KIND OF BUSINESS OR INDUSTRY Eastern Pro. Corp Hagerstown Wash Con 11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Nichols 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Korean 16. SOCIAL SECURITY NO. 218-30-9253 17. INFORMANT Mrs Doris T. Nichols Hag R # 3 Address Garis Shop Road		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. Four hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 67 , to 9/12 , 19 67 , that (I) (we) last saw the deceased alive on 9/12 19 67 , and that death occurred at 11:15 p.m. from causes and on the date stated above.			
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.		22b. DATE SIGNED 9/13/67 22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16/67	
23c. NAME OF CEMETERY OR CREMATORY Coseytown, Cemetery		23d. LOCATION (City or Town) (County) (State) Coseytown, Penna.	
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR SEP 19 1967 25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

Very truly yours,

[Illegible Signature]

Enclosure

SEP 12 1951

U.S. DEPARTMENT OF JUSTICE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

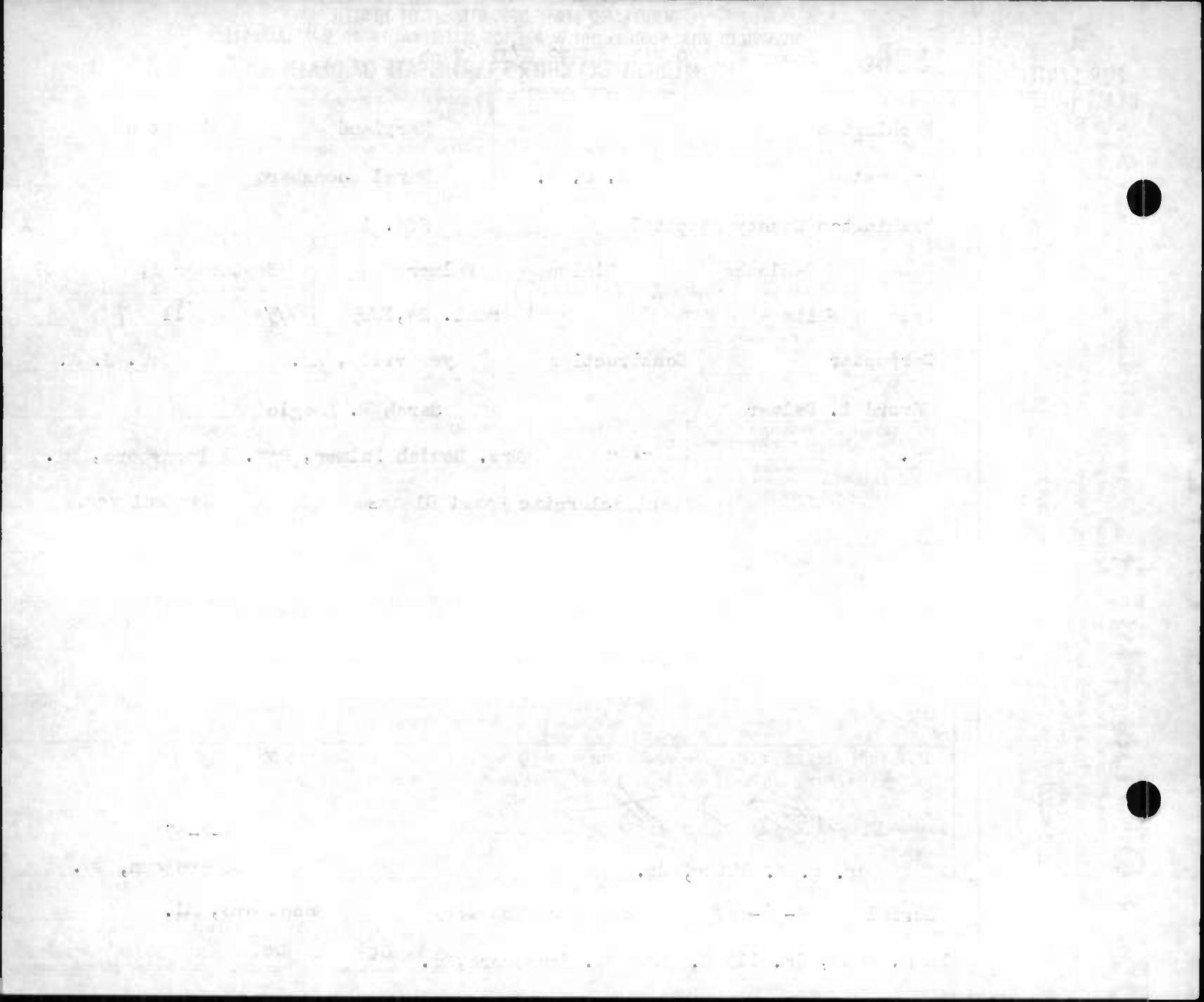
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #8 & 9 Film #G392 9/21/67 nh

13066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13070

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rfd. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gaulesba Middle Blaine Last Palmer				4. DATE OF DEATH Month September Day 1 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Sept. 24, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 11 Days 7		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Myersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward L. Palmer				14. MOTHER'S MAIDEN NAME Sarah E. Koogle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-16-0911		17. INFORMANT Address Mrs. Beulah Palmer, Rfd. 1 Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Several years 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-2-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9- 4- 67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13067

13071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>239 N Potomac</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Lou Poper</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1928</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Hull</u>		14. MOTHER'S MAIDEN NAME <u>Zola Mae Jenkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. W.L. Poper</u>		Address <u>239 N. Potomac St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma breast</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Distal and local Metastasis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>15 Sept., 1967</u> to <u>16 Sept., 1967</u> that (I) (<u>we</u>) last saw the deceased alive on <u>16 Sept., 1967</u> and that death occurred at <u>11:05</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Frank E Brumback</u>		22b. DATE SIGNED <u>16 Sept 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank E Brumback</u>		22d. ADDRESS <u>119 King St Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>W. C. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 1967</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1

THE STATE OF TEXAS,
COUNTY OF DALLAS,
ss. I, the undersigned, Clerk of the County Court,
do hereby certify that the within and foregoing
is a true and correct copy of the original
as the same appears from the records of the
County Court of Dallas County, Texas.

WITNESSED my hand and the seal of the County Court
at Dallas, Texas, this 1st day of January, 1902.

CLERK OF COUNTY COURT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13068

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13072

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>225 East Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Brian</u> Middle <u>Lee</u> Last <u>Rinehart</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1966</u>	9. AGE (In years lost birthday) yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>28</u>	IF UNDER 24 HRS. Days <u>28</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Rinehart</u>				14. MOTHER'S MAIDEN NAME <u>Kathleen Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. & Mrs. James A. Rinehart 225 East Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition, Severe</u> <u>7720</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>9-5-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

W. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13069					13073				
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 39 W. Wilson Blvd.					d. STREET ADDRESS 39 W. Wilson Blvd.				
3. NAME OF DECEASED (Type or print) First Henry Middle Richard Last Rouse					4. DATE OF DEATH Month September Day 12 Year 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-01		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY television repair		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Benjamin F. Rouse					14. MOTHER'S MAIDEN NAME Nellie Richardson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 1 578-10-0102A		17. INFORMANT Plaige Rouse, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH Hours Four years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 5/4 , 1965, to 9/12 , 1967, that (I) had last saw the deceased alive on 9/9 , 1967, and that death occurred at 7:45 AM , from the causes and on the date stated above.									
22a. SIGNATURE Donald E. Martin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/12/67		
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.					22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-14-67		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

Ans. 43. 1000000

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WILSON DISTRICT		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE INDIANA b. COUNTY MARION c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) INDIANAPOLIS d. STREET ADDRESS 3024 S. KEYSTONE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle SANDERS Last SANDERS		4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 10, 1931 9. AGE (In years last birthday) 36 yrs. IF UNDER 1 YEAR: Months 36 Days 36 Hours 36 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING CO.	11. BIRTHPLACE (State or foreign country) INDIANA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DALE SANDERS	
14. MOTHER'S MAIDEN NAME HELEN ZIMMERMAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) KOREAN WAR	
16. SOCIAL SECURITY NO. 307-32-3262		17. INFORMANT MRS. PHYLLIS SANDERS, INDIANAPOLIS, INDIANA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull 823.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor-trailer ran off road, throwing occupant forward.	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 9/28 1967	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Interstate 70	20f. (City or town) (County) (State) West of Hagerstown, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 9/28/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 NORTHERN AVE. Address (Street, city, town, or county) HAGERSTOWN, MD.			
22. DATE SIGNED		23a. REC'D BY REGISTRAR	
23b. DATE THEREOF 9/29/67		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town or county) (State)		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25. ADDRESS	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13075

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 831 View St.				d. STREET ADDRESS 831 View St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emily Middle Margaret Last Seifert				4. DATE OF DEATH Month September Day 12 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-98	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Otha H. Alburtis				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-28-0517		17. INFORMANT Margaret Bittinger, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma 1909 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 10 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 67 , to 9/12 , 19 67 , that (I) (we) last saw the deceased alive on 9/6 , 19 67 , and that death occurred at 3:45 P.M., from the causes and on the date stated above.							
22a. SIGNATURE Donald E. Martin				22b. DATE SIGNED 9/13/67		22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.	
22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.		22e. REC'D BY REGISTRAR SEP 14 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-15-67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Page 4 should be designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/19/67
A34

FOR STATE
HEALTH DEPT.

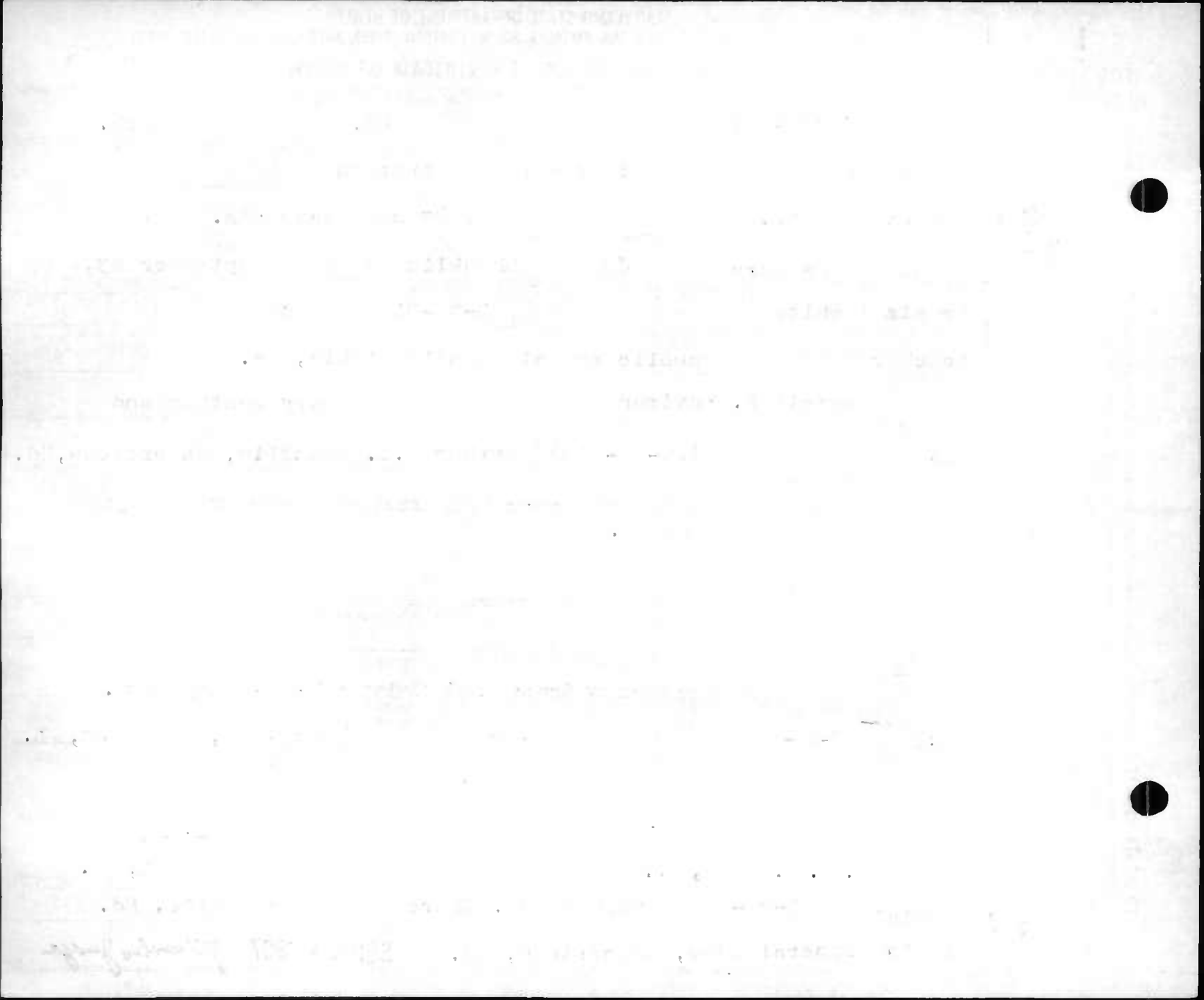
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13076

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11½ years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ravenwood Hts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle June Last Shanklin		4. DATE OF DEATH Month September Day 23 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-31
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY public school	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Russell L. Davison		14. MOTHER'S MAIDEN NAME Mary Southerland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 164-26-9394	
17. INFORMANT Arthur F.B. Shanklin, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spinal Cord Damage With Fracture Of Cervical 8124 DUE TO Vertebra. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck in back by truck wheel flying off of passing truck.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 2:38 p.m. 9-23-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		22. DATE SIGNED 9-25-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-26-67	
23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem. Church		23d. LOCATION (City or Town) (County) (State) Millersville, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 28 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 38 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 135 North Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 135 North Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Victor Shannon						4. DATE OF DEATH Month September Day 14 Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-88		9. AGE (In years last birthday) 79 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman car shop				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Johnson F. Shannon						14. MOTHER'S MAIDEN NAME Barbara Eckenrode					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 717-07-9309		17. INFORMANT Ann N. Shannon, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2-2-1967, to 9-14-1967, that (I) (we) last saw the deceased alive on 9-7-1967, and that death occurred at 7:30 P.M., from the causes and on the date stated above.											
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-15-67			
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.						22d. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-17-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE 			

Washington

Washington

100 North Ave.

Illinois

Motor

Admission

Male, White

in line

Person on ship

Johnson, J. Shannon

717-97-9200

Ann. J. Shannon, Secretary

Washington State

Washington State

Washington State

Washington State

Washington State

Washington State

Washington State

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13074

CERTIFICATE OF DEATH

13078

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayestown</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u>		753	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>State Line, Pa.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ORPHA</u> Middle <u>E.</u> Last <u>SHINDLE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/1887</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Katie Ellen Cump</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>266-98-3091</u>		17. INFORMANT <u>Merle F. Shindle - State Line, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage - 3 days</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subarachnoid hemorrhage</u> DUE TO (c) <u>20475-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20475-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/30/67</u> to <u>9/16/67</u> , that (I) (we) last saw the deceased alive on <u>9/12/67</u> , and that death occurred at <u>6:20 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>9/16/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W.C. [Signature]</u>	
22d. ADDRESS <u>[Signature]</u>				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>9/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Wash. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>A.C. Minnich - Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Franklin

State of Ohio

1
The undersigned, James C. Crawford,
do hereby certify that James C. Crawford
is the owner of the State of Ohio
and that the same is now in the hands of
the State of Ohio and is now being
used for the purpose of the State of Ohio

[Faint, illegible text, possibly a signature or additional certification]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13079

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. STREET ADDRESS 162 East Franklin St.	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Snyder		4. DATE OF DEATH Month September Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 / 8 / 1898
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. BIRTHPLACE (State or foreign country) Franklin Co. Penna.	
13. FATHER'S NAME Edward H. Poper		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 203-10-9474	
17. INFORMANT A. Earl Snider, Greencastle, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacerated brain and subdural hematomas 9000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs	
20c. TIME OF INJURY Hour 8:15 a.m. 9/1/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Greencastle Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave., Hagerstown, Md.	
22. DATE SIGNED 9/6/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Greencastle, Franklin Co. Pa.	
24. FUNERAL DIRECTOR Howard N. Zimmerman, Greencastle, Pa.		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Washington, D. C. 20535
January 1, 1938

Washington, D. C. 20535
January 1, 1938

Washington, D. C. 20535
January 1, 1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

10/19/67
A34
BPD

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Spring, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence Big Spring, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olive Middle Lucy Last Snyder		4. DATE OF DEATH Month Sept. Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1890
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home duties	
11. BIRTHPLACE (County & State, or foreign country) Salem W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel S. Smith		14. MOTHER'S MAIDEN NAME Laura V. Riggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-50-3822	
17. INFORMANT Frederick H. Snyder, Big Spring, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis Cerebral and generalized. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 28 , 19 67 to Sept. 15 19 67 , that (I) (we) lost the deceased alive on Sept. 11 19 67 , and that death occurred at 7.15 , from causes and on the date stated above.			
22a. SIGNATURE W.T. Layman, M.D.		22b. DATE SIGNED Sept. 16, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 100 Prof. Arts Bld. Hagerstown.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/67	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring Md.	
24. FUNERAL DIRECTOR Margaret Rowland		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

Residence

121 Spring St.

121 Spring St.

Age 57

Male

White

Married

Occupation

U.S.A.

U.S.A.

U.S.A.

U.S.A.

Address of next of kin and relationship.

Signature of Registrar

1911

1911

1911

100 No. 1st St. New York

100 No. 1st St. New York

100 No. 1st St. New York

100 No. 1st St. New York

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13077

13081

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>19 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Mildred</u> Last <u>Solt</u>		4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1902</u>
9. AGE (In years lost birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Eckart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Barnard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-3847</u>	
17. INFORMANT <u>J. E. Solt Jr.</u>		Address <u>1369 N. VAN DORN ST. Alexandria, Va. 22304</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>2 days.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>Sept 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		22b. DATE SIGNED <u>9/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Potomac St Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Eckhart-Allegany Maryland</u>
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

733-3575

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT : [Illegible]

DATE : 10/10/50

RE : [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

41. [Illegible]

42. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13078

CERTIFICATE OF DEATH

13082

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY in 1b 4 Mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1106 Oak Hill Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ethel Last Spangler				4. DATE OF DEATH Month Sept. Day 23 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Emmertsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Hess				14. MOTHER'S MAIDEN NAME Agnes Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT John H. Spangler Address 1106 Oak Hill Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days 8 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG. 21 , 19 67 , to SEPT. 23, 1967 , that (I) (we) last saw the deceased alive on SEPT. 23 , 19 67 , and that death occurred at 7:00 M, from causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Potomac St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash. Md.	
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.				25a. REC'D BY REGISTRAR ACT 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
IN SENATE
January 10, 1907.

REPORT OF THE

COMMISSIONER OF

THE STATE

OF THE LAND OFFICE

FOR THE YEAR 1906.

ALBANY:

1907.

WILLIAM C. BROWN,

PRINTED BY

THE STATE

OF THE LAND OFFICE

ALBANY:

1907.

WILLIAM C. BROWN,

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> 13079 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13083 </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>45 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Convalescent Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>211</u> d. STREET ADDRESS <u>785 S. Potomac St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>May</u> Last <u>Stouffer</u> 4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>19 67</u>						5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 14, 1888</u> 9. AGE (In years last birthday) <u>79</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Shippensburg, Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Edward Martin</u> 14. MOTHER'S MAIDEN NAME <u>Emma Hippensteel</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>218-30-8799</u> 17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Helen Mowbray 785 S. Potomac St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>304X Stopped eating, strength</u> DUE TO (b) <u>3-44</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic enteritis, acute cystitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>5 April, 1957</u> , to <u>5 Sept., 1967</u> , that (I) (we) last saw the deceased alive on <u>31 Aug.</u> 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Richard T. Bixford</u> M.D. 22b. DATE SIGNED <u>9/6/67</u>						22c. ADDRESS <u>1135 Potomac Ave Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 11 1967</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

STATE OF NEW YORK
IN SENATE
January 10, 1911

Health

Medical

Sanitation

Sanitation

Sanitation

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Sanitation

Richard T. Buntford, M.D., Secretary

Sanitation

Wm. C. Buntford

Sanitation

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13080

13084

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN ID 1 DAY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 108 EAST IRVIN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DONALD LEE SWEIGERT, SR.					4. DATE OF DEATH SEPTEMBER 14, 1967		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 28, 1937	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE TRUCK DRIVER					10b. KIND OF BUSINESS OR INDUSTRY CITY OF HAGERSTOWN		11. BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES E. SWEIGERT		14. MOTHER'S MAIDEN NAME MARY R. ASHBAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 218-30-8571		17. INFORMANT MRS. LINDA M. SWEIGERT, HAGERSTOWN, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trans-section of cervical spine 9021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fractured neck DUE TO (c) sudden		INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Victim fell off scaffolding									
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 9/14 1967					20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Washington Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					ACTUAL SIGNATURE <i>Howard N. Weeks</i> EXAMINER'S NAME (Type) HOWARD N. WEEKS, M.D.					22. DATE SIGNED 9/16/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 580 NORTHERN AVE. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 9/17/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY			23d. LOCATION (City, town or county) (State) HAGERSTOWN, WASH. CO. MARYLAND						
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "WASHINGTON COUNTY HOSPITAL" and "DONALD" are visible.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any county is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM
SM 1/63

13081

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13085

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Williamsport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 6 months				d. STREET ADDRESS 821 Virginia Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUD Middle PRISCILLA Last TAYLOR				4. DATE OF DEATH Month Sept. Day 4 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1880	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 11 Days 13		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housekeeper		11. BIRTHPLACE (State or foreign country) Williamsport, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George P. Growe				14. MOTHER'S MAIDEN NAME Jennie Wolfe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 2008 Welford Ave. Mrs. Evelyn C. Wolford Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X Cerebral atherosclerosis and Gen'l arteriosclerosis and Terminal pneumonia Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } XXXXX (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Fractured left hip							INTERVAL BETWEEN ONSET AND DEATH years 2 wks.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell getting up from chair			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8/9/67 p.m. 5		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Homewood Nursing Home Wmspt. Wash. Md.		20f. (City or town) (County) (State) Wmspt. Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/6/67			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 7, 1967		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
22d. LOCATION (City, town, or county) (State) Williamsport, Md.							
23. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Md.				24a. REC'D BY REGISTRAR DATE SEP 7 1967			
24b. REGISTRAR'S SIGNATURE Charles J. J...							

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

OFFICE OF THE
DIRECTOR

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13086
CERTIFICATE OF DEATH
13086

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY McConnellsburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. STREET ADDRESS 204 L. W. E.			
3. NAME OF DECEASED (Type or print) First Frederick Middle Shaner Last Teeple				4. DATE OF DEATH Month Sept. Day 26 Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 20, 1900 66	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10. CITIZEN OF WHAT COUNTRY? Penna.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repairman				10b. KIND OF BUSINESS OR INDUSTRY typewriter sales			
11. BIRTHPLACE (County & State, or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? Penna.			
13. FATHER'S NAME George O. Teeple				14. MOTHER'S MAIDEN NAME Margaret Shaner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 190-09-3443		17. INFORMANT Mrs. Helen Bishop, Pittsburg, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Ventricular Fibrillation 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours A 1/2 yr -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-11, 1967 , to 9-26, 1967 , that (I) (we) last saw the deceased alive on 9-26 1967 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker, M.D.				22b. DATE SIGNED SEP 29 1967		22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.	
22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740				22e. REC'D BY REGISTRAR Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City, town or county) (State) Mt. Lebanon Twp. Penna.	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.				25a. REGISTRAR'S SIGNATURE Charles Judge			

WASHINGTON COUNTY

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Washington County Hospital

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Frederick Thomas

Nov 20, 1900

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1900-1901 Mrs. Helen Thomas, Washington, Tenn.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Wk. 2 Dy.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rfd. 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Ellen Toms		4. DATE OF DEATH Month Day Year September 14, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 7, 1896
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 0 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Warrenton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David S. Rector		14. MOTHER'S MAIDEN NAME Mary E. Brandt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-09-9008	
17. INFORMANT Mr. Hubert W. Tomas, Rfd. 1 Boonsboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Effusion DUE TO (b) Metastatic Adenocarcinoma DUE TO (c) Adenocarcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X		INTERVAL BETWEEN ONSET AND DEATH 36 days 3 years 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 57 , to 9-14 , 19 67 , that (I) (we) last saw the deceased alive on 9-14 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED 9/15/67	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22d. ADDRESS 998 Potomac Avenue, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-16-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.			

UNITED STATES OF AMERICA

Department of Justice

Federal Bureau of Investigation

Washington, D.C.

Memorandum for the Director

Subject: [Illegible]

Reference is made to [Illegible]

It is recommended that [Illegible]

Very respectfully,
[Illegible Signature]

Special Agent in Charge

Enclosure

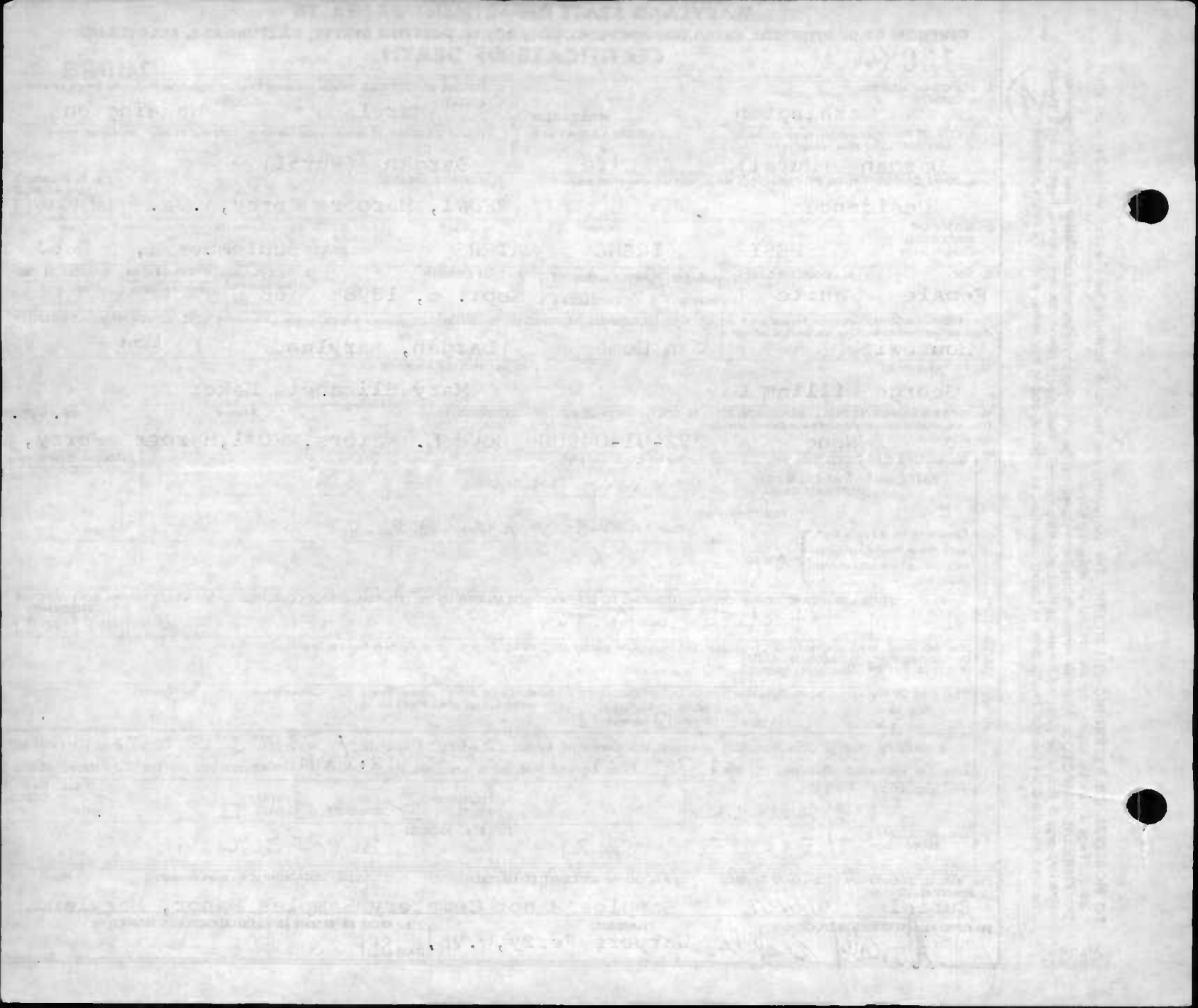
Very truly yours,
[Illegible Signature]

Special Agent in Charge

Enclosure

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13084											
13088											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dargan (Rural)				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dargan (Rural)				21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Residence						d. STREET ADDRESS RFD#1, Harpers Ferry, W.Va.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ESSIE IRENE WATERS			4. DATE OF DEATH Month Day Year September 3, 1967								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1898		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Dargan, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George William Gay						14. MOTHER'S MAIDEN NAME Mary Elizabeth Baker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Boyd L. Waters, RFD#1, Harpers Ferry, W.Va.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 1, 1967, to Sept. 3, 1967, that (I) (we) last saw the deceased alive on Sept 3, 1967, and that death occurred at 12:00 AM, from the causes and on the date stated above.											
22a. SIGNATURE J. H. Secord						M.D.		22b. DATE SIGNED 9-4-67			
22c. PHYSICIAN'S NAME (Type) JOSEPH SECORD JR						22d. ADDRESS 300 WS BORO Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/6/67		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery			23d. LOCATION (City, town or county) Samples Manor, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE J. Donald Eckles						ADDRESS Harpers Ferry, W.Va.		25a. REC'D BY REGISTRAR DATE SEP 8 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13085

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13089

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d. STREET ADDRESS 666½ N. Prospect St.	
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last WATERS		4. DATE OF DEATH Month September Day 28 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Carpentry	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Waters		14. MOTHER'S MAIDEN NAME Emma Haller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-01-1241	
17. INFORMANT Mary E. Schroyer, Middletown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Congestive Heart Disease DUE TO (b) Arteriosclerosis gen'l Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE H. N. Weeks		22b. DATE SIGNED 9/30/67	
22c. PHYSICIAN'S NAME (Type) H. N. WEEKS		22d. ADDRESS 580 Northham Av Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran	23d. LOCATION (City or Town) (County) (State) Middletown, Fred. Co. Md.
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Washington Co. No. 100-1000000

John J. ...

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13086

CERTIFICATE OF DEATH

13090

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Road</u>		d. STREET ADDRESS <u>Frederick Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Allen</u> Last <u>Weaver Jr.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1923</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Allied Van Lines</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Zullinger, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Allen Weaver</u>	
14. MOTHER'S MAIDEN NAME <u>Della C. Robinson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-16-0507</u>		17. INFORMANT <u>Mrs. Ruth E. Weaver</u> Address <u>Funkstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1967</u> , to <u>Sept 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/29 1967</u> , and that death occurred at <u>4:17</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Edson B. Moody</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody M.D.</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>OCT 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13091

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>76 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Convalescent Home</u>		d. STREET ADDRESS <u>335 S. Mulberry St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Bertha</u> Last <u>Werst</u>		4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1873</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Newville, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Hefflefinger</u>		14. MOTHER'S MAIDEN NAME <u>Louise Brady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8005D</u>	
17. INFORMANT <u>Mr. R.R. Werst</u>		Address <u>243 E. Potomac St. Williamsport, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Pneumonia</u> DUE TO <u>and</u> (b) <u>Arteriosclerotic Heart Disease &</u> DUE TO <u>General Arteriosclerosis & Senility</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 Days</u> <u>25-30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1966</u> to <u>Sept 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 9, 1967</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Ditto III</u>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		22d. ADDRESS <u>217 W. Wash. St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/27/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horne</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 27 1967</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13088

13092

1. PLACE OF DEATH a. COUNTY WASHINGTON HAGERSTOWN MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA. b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAMBERSBURG HAGERSTOWN			c. LENGTH OF STAY IN TB 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAMBERSBURG PENNA.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL				d. STREET ADDRESS 1399 Stanley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Robert Last Windemuth				4. DATE OF DEATH September 3rd. 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14th. 1917	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Body Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Auto Body Work		11. BIRTHPLACE (County & State, or foreign country) Cumberland Md.	
13. FATHER'S NAME George Windemuth				14. MOTHER'S MAIDEN NAME Loretta Hadra			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.# 2		16. SOCIAL SECURITY NO. 214-05-4469		17. INFORMANT Mrs. Clarence R. Windemuth-Chambersburg Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 4201 DUE TO (b) Coronary Atherosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 3 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-31 , 19 67 , to 9-3 , 19 67 , that (I) (we) last saw the deceased alive on 9-2 , 19 67 , and that death occurred at 14 M, from causes and on the date stated above.							
22a. SIGNATURE Charles C. Spencer				22b. DATE SIGNED 9-3-67		22c. PHYSICIAN'S NAME (Type) Charles C. Spencer	
22d. ADDRESS 1455 Prospect St. Hagerstown				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Chambs.-Greene Twp.-Franklin	
24. FUNERAL DIRECTOR ROBERT G. SELLERS				25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE Charles C. Spencer	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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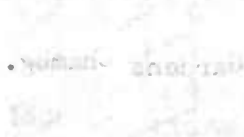
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